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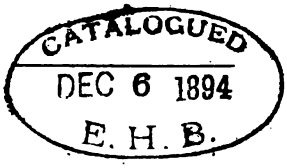


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## ORIGINAL ARTICLES.

### TREATMENT OF OLD CASES OF HIP DISEASE.

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On the streets of any of our larger cities one will see many examples of cripples walking with one limb either dangling in the air worse than useless, due to the extreme flexion at the hip with abduction, or else they will be seen walking very imperfectly on a high built-up shoe. It is the treatment of these cases and also that of convalescent hip disease to which I wish to call your attention.

There is no doubt that if convalescent cases of hip disease were carefully and persistently treated during the long period to complete recovery, whatever deformity had existed up to this time, and that which accompanies this period, could be entirely overcome without operation. During the convalescent period, the spasm of muscles having entirely disappeared, traction is not considered necessary—a brace that simply gives protection to the joint in walking is sufficient. This protection from jar in walking is especially required in the first part of the step, *i. e.*, at the time when the heel is brought to the ground.

This can be easily accomplished by using the caliper, the upper part of which is similar to the ordinary hip brace with stem, pelvic band and perineals, the lower part cylindrical in shape, turned at right angles to the stem and passing through a hollow cylinder in the heel. The stem and perineals should be of such length that the heel of patient, though inside the shoe, should bear no weight, all weight being taken up by perineals.

The brace may be jointed at the knee, and the patient can then get about quite easily and with comfort. In small children the joint is unnecessary, and in clinical patients the question of additional expense debars the joint. Dr. A. B. Judson, of New York, devised a brace for these cases, using one perineal band—he calls it the perineal crutch.

When shall a case of hip disease be considered to have progressed far enough to permit the removal of the extension splint and the substitution of a convalescent brace? The solution of this problem is much a matter of judgment. It is better to allow the extension splint to be worn unnecessarily long than for the substitution to be made too soon. It is essential that one wait until all pain and acute symptoms have been absent for some months, and there exists no muscular spasm. Likewise during the convalescent stage it is better that the protective splint be worn longer than necessary than for too short a period. From one to three years will usually be necessary. The discontinuance of the protective splint should

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be a gradual process, the splint only being removed part of the day or for short walks; but when the patient intends to do considerable walking the splint should be resumed. After some days' or weeks' trial of leaving off the protective splint, should it be found that the joint is becoming painful and sensitive, it is better to return to the constant wearing of the splint for six months or a year longer.

OLD HIP CASES WITH DEFORMITY.

The deformities requiring correction are flexion and adduction. These deformities produce an apparent shortening of the limb, or, as it is called, "practical shortening," in contradistinction to real shortening, which latter may be quite small while the former is considerable. Abduction exists as a deformity, but, as it increases the practical length of a limb already actually shortened by disease, the deformity is rather of an advantage than otherwise and does not ordinarily require correcting, unless excessive. In adduction, besides shortening, there is tilting of the pelvis. In order to bring the foot down in the act of walking in those cases where there is fixation at a moderate angle of flexion, motion must take place at the spine, thus producing lordosis; and where the angle of deformity is great, it may be nearly or quite impossible to get the foot down. In these cases a practical lengthening of the leg is obtained by building up the shoe. When the deformity is of such a grade as to seriously interfere with progression, surgery is called upon for relief from the condition.

I have been surprised in several instances of old cases of hip disease with considerable deformity where it appeared that the ankylosis was very firm and bony, that on the application of continuous extension in bed for a few weeks the deformity would be considerably reduced. This had led me to believe that many if not most of these cases should be given a trial of extension in bed for reduction of deformity before proceeding to operative measures, or at least before performing an osteotomy. By the use of adhesive straps to the leg, with weight and pulley, extension can be obtained, and counter-extension secured by the foot of the bed being raised or by the use of the perineals with attachment to head of bed. With considerable adduction it is a good plan to make counter extension by a perineal to the other hip. After a trial of extension in bed with a failure to reduce deformity, there remains as means of correction: 1. Brisement forcé, with or without myotomy, tenotomy, faciotomy, etc. 2. Osteoclasis. 3. Osteotomy.

Brisement forcé should be limited in use to those cases in which there is evidently only fibrous ankylosis. There is the danger in the use of too much force of fracturing the thigh bone at an unfavorable point; and again there is the danger of relighting the tubercular process. If there is considerable shortening of the flexor or adductor muscles, or of the fascia, subcutaneous division of these structures will greatly aid in rectifying the position of the limb. Frequently the capsule of the joint is found shortened, and, in some cases, an open incision down to the joint (cutting everything which obstructs, including the capsule) is found to be necessary before the limb can be straightened. After the limb is straightened it should be encased in a plaster-of-Paris spica, or fixed by means of extension. Absolute rest is necessary for a variable period; and should there be heat about the joint, giving evidence of some inflammation being produced, bags of ice placed about the hip frequently reduces this activity in a short space of time. After all danger of inflammatory action is past the patient should be fitted with a protection splint and allowed to get about.

Osteoclasis and osteotomy are reserved for those cases in which there exists bony union or a fibrous ankylosis of a very firm character. It is true that osteoclasis is sometimes the result of brisement forcé, but this is accidental and not the desire of the operator. In performing osteoclasis appliances are used to hold the pelvis rigid while force is exerted on the limb sufficient to fracture the bone or break up the ankylosis; but the point of fracture is so uncertain and the operation as a whole lacks precision and is so unscientific that it has been replaced by osteotomy. Osteotomy is by far the most satisfactory operation for the rectification of deformity in a bony ankylosed hip. This operation has been performed at different points near the head of the bone. Adams' operation was a division of the bone at the neck. Sayre and Barwell divided the bone between the greater and lesser trochanters, while Gant

performed osteotomy just below the trochanter minor.

This latter operation, now admitted the best by most surgeons, is based on the anatomical reasoning that the resistance of the psoas and iliacus being set free, a return of the deformity is not to be expected; also that by operating at a lower point than had formerly been done, the operator is more likely to strike healthy bone and less likely to relight the old inflammation.

GANT'S OPERATION.

Having determined that all inflammatory action in the joint has ceased and that probably nothing short of an osteotomy will correct the deformity, the night before the operation the thigh is encased in a dressing of soft soap, or soap liniment, with proper outside bandages. By the next morning it will be found that the outer layers of epidermis are softened and will readily wash off. Then ether and alcohol may be used to remove any oily or soapy substances remaining. The patient, under an anæsthetic, is placed on his side with a sand bag between the thighs. The trochanter minor having been marked out, the osteotome is introduced at a point just below the level of this trochanter, on the outer aspect of the thigh. The best osteotome for this work is an instrument whose length should be about seven inches, width of cutting-edge three-eighths to one-half inch. It should be tempered to a hardness between that of a cold-chisel and the carpenter's chisel. The handle should be marked every half inch, to show the depth to which the instrument has penetrated. This is more than theoretically indicated, for I have seen the osteotome driven through the thigh and one and one-half inches into the sand bag. In introducing the instrument into the thigh, the edge of the blade is held parallel to the axis and is made to penetrate the skin, fascia, muscles, periosteum, down to the bone; the blade is then turned at right angles to the limb, and, with sharp blows of a mallet, preferably a wooden one, the osteotome is driven through the bone, being loosed and driven at different angles after every two or three blows. When only a shell of bone remains, the instrument is withdrawn and the fracture completed by manual force. The limb is then brought down to as nearly the horizontal plane as possible, at the same time putting it in a position of abduction. This abduction is to increase the practical length of the limb and is thereby a positive advantage. There is little or no bleeding. The wound in the skin is very small and is covered over by oiled silk or rubber gauze; over this is the antiseptic dressing, and over all is applied a plaster-of-Paris spica reaching from the axilla to the ankle, and it may also include the foot with advantage. The limb is left in the plaster spica from four to six weeks, after which it is removed, the parts examined and measure is taken for a convalescent walking-splint. By the time it is made and applied the limb is strong enough to be used with the aid of the splint. The convalescent splint is worn for three to eight months, or longer.

As a result of these operations we have a practical lengthening of the limb from one to four inches, the limb placed in nearly a line with the body, and in walking the spine is held upright instead of being lordosed, as is required with a flexed limb.

Some time ago I reported in detail the results in sixteen cases following Gant's operation. I give a summary of that report in the table here appended.

(See table on page 4).

From this table we see that the average age of the patient was eleven years, the oldest being sixteen, the youngest five and one-half. We find that the hips were held fixed at an average of 135°, *i. e.*, half way between a straight leg and one held at a right angle. By the operation they were brought down on an average of 36°, thus bringing the leg to within 9° of being perfectly straight (171°). The average shows a practical shortening of two and a half inches before the operation and only one inch shortening after the operation. There was no motion at the hip in any case before operation, while after operation there was motion at the joint in several cases. All of the cases were improved in their ability to walk—some greatly, others only moderately. There were no untoward symptoms in a single case. We therefore conclude that the operation is a great boon to those having considerable deformity as the result of hip disease.

| Case. | Age. | Time Spica Remained On. | Angle of Fixation Before Operation. | Amount Leg was Brought Down. | Greatest Extension After Operation. | Adduction before Operation. | Practical Shortening Before Operation. | Increase in Practical Length. | Practical Shortening After Operation. | Am't of Motion at Hip before Operation. | Amount of Motion at Hip After Operation. | Ability to Walk After Operation. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 12 yrs. | 8 weeks. | 125 deg. | 40 deg. | 165 deg. | . . . . . | 4 inches. | 2½ inches. | 1½ inches. | None. | Small angle. | Walking well. |
| 2 | 13 " | 4 " | 135 " | . . . . | . . . . | Considerable. | 8 " | 6 " | 2 | None. | . . . . . | Limb strong. |
| 3 | 14 " | . . . . | 155 " | . . . . | . . . . | Adducted. | 2 " | 2 " | None. | None. | Small amount | Wearing brace. |
| 4 | 6 " | 4 " | 150 " | 20 " | 170 " | . . . . . | 1 " | ½ " | ½ inch. | None. | . . . . . | " " |
| 5 | 8 " | 5 " | 145 " | 25 " | 170 " | . . . . . | 1¾ " | ½ " | 1¼ " | None. | Slight motion | " " |
| 6 | 9 " | 4 " | 130 " | 40 " | 170 " | . . . . . | 1 " | ½ " | ½ " | None. | " " | . . . . . |
| 7 | 7 " | 4 " | 120 " | . . . . | . . . . | 24 degrees. | 3½ " | 1½ " | 1¾ " | None. | . . . . . | Walks well. |
| 8 | 10 " | 4 " | 130 " | 45 " | 165 " | . . . . . | 3¼ " | 1¼ " | 2 " | None. | Considerable. | " " |
| 9 | 5½ " | 4½ " | 130 " | 40 " | 170 " | . . . . . | ½ " | None. | ½ " | None. | . . . . . | . . . . . |
| 10 | 16 " | 5 " | . . . . | . . . . | . . . . | . . . . . | 4½ " | 2½ inches. | 2 " | . . . | Considerable. | Walking with comfort. |
| 11 | 15 " | 6 " | 135 " | . . . . | . . . . | . . . . . | None. | None. | None. | None. | . . . . . | Greatly improved. |
| 12 | 9 " | 4 " | 135 " | 40 " | 175 " | . . . . . | 4 inches. | 1½ inches. | 2½ inches. | None. | 40 degrees. | Walks well. |
| 13 | 14 " | 4 " | 130 " | 45 " | 175 " | . . . . . | 2 " | 1 " | 1 " | None. | None. | Much improved. |
| 14 | 6 " | 4 " | 135 " | 41 " | 176 " | . . . . . | None. | ½ " | ½ (larger) | None. | None. | . . . . . |
| 15 | 15 " | . . . . | . . . . | . . . . | 172 " | . . . . . | . . . . . | . . . . . | 3½ inch. | None. | None. | Walks well. |
| 16 | 14 " | 5 " | 140 " | 30 " | 170 " | . . . . . | 2½ " | 1¾ " | ¾ " | None. | None. | " " |
| Average. | 11 yrs. | 4 wk. 5d. | 135 deg. | 36 deg. | 171 deg. | . . . . . | 2¼ inches. | 1½ inches. | 1 inch. | . . . | . . . . . | All were improved. |
| Maximum. | 16 " | 8 " | 155 " | 45 " | 176 " | . . . . . | 8 " | 6 " | 2 " | . . . | 40 degrees. | Greatly improved. |
| Minimum. | 5½ " | 4 " | 120 " | 20 " | 165 " | . . . . . | 0 " | 0 " | 0 " | . . . | 0 " | Some moderate improvement. |

# COMMUNICATIONS.

## WHAT THE MORTALITY SHOULD BE IN MATERNITY HOSPITALS OR PRIVATE OBSTETRIC PRACTICE.

JOSEPH PRICE, A.M., M. D., PHILADELPHIA.

There is very much skepticism as to the statistics of mortality in maternities and private practice. About one fact there can be no dispute, that is, that there are too many deaths from infection and septic causes. The mortality from these causes both in maternities and in private practice, should be nil. In hospital and private practice there will be occasional unavoidable deaths from chronic kidney disease, consumption, cancer or other incurable disease. The common causes of mortality are avoidable and are wholly absent in the Preston Retreat and other of our maternities. Labor is a perfect natural process when all the conditions are normal and an ideal cleanliness is rigidly observed. Where the conditions are abnormal or there occurs those accidents to parturition prompt and skillful surgery will save life in nearly all cases. Our obstetrics have been aided by our greatly advanced knowledge of the structures of parts, our increased knowledge of puerperal conditions, both normal and pathological. The fevers of the lying-in period have been banished from the lying-in Hospital—formerly rarely free from these and frequent in private practice. The intelligent and conscientious physicians by a more careful watching of cases have made the accidents of maternity less frequent and fewer mothers are hurried to premature death.

Deaths in child-birth are noted more than formerly and the causes inquired into. Happily the mother begins to count for somebody and the causes for her needless sufferings are reckoned. There are no cases more dependent upon the care and ability of others than that of the mother and her new-born infant. There is no responsibility more vital than that of those attendant upon them. They should have skill and knowledge of their duty in all its manifold relations. The responsibility in such cases is too often treated lightly. It would be startling to know, with all our boasted advances, how many mothers and infants are sacrificed to ignorance. The awkward, slovenly and unskillful obstetrician, bad hygienic invironments and ignoront nursing—these have the most to do with the mortality in these cases. It is the skilled experience of the physician, careful, intelligent, and trained nursing, the cleanliness and better sanitary conditions that give to maternities their advantage. Make external conditions healthy, and there will be few or no deaths in maternity cases from septic causes. The advantages of the Preston Retreat, the Sloan, and maternites of modern build, lies in their construction with scrupulous regard to the best hygienic arrangement, in the use of appliances which have stood the severest tests of sanitary science, where the patients are isolated, far removed from the channels of septic infection. With the advance of general intelligence there is a better recognition of the vital importance of the best hygienic conditions, and stronger and louder grows the demand that, in the service of these institutions, to the bedside of mothers shall be called only those of skill, and the knowledge which comes of long and patient study and wide experience. The fact is coming out into strong light that two lives are involved. Men pass out of our colleges to active maternity work without ever having attended a maternity case. The time is not distant in the future when the directors of maternity hospitals will not dare to appoint a man to *direct* or have *official charge* of such *vital interests* without a rich, practical experience and sound judgment. They will be held responsible for the success of their trust, and it is to be hoped will be held *criminally* responsible for the choice of a person to such trust with no more pride of personal cleanliness and cleanliness of environments than a stable boy, dirty in all the term implies—morally and personally. The physician who stands at the bedside of the mother should have knowledge of

his work in all its details, should be ready, quick and full of resource, and have morals upon which the most penetrating search light can be turned.

The Preston Retreat had thirteen hundred and thirteen consecutive cases without a death from any cause. Fourteen hundred cases with one death from mania. The Board of Directors and friends of the institution may well feel proud of this Record when it is contrasted with the good records of the best maternities of Europe. At the Imperial Lying-in Hospital at Vienna the death rate from 1881-7 was 7 per 1,000. At the Paris maternity, from 1882-7 the average had been 11 per 1,000. At one of the chief materanties in England 6 in 1,000 and through out England and Wales was 1 in 200.

But the mortality in child-birth does not represent all the mischief. By ignorance and want of skill many women are rendered sufferers for life, useless to their families, friends and society. There are advantages in favor of the mothers in rural sections over those of the dense populations of the cities—they have plenty of fresh air, healthy and moderate food and with them there is less *ignorant and vulgar tight rope lacing.*

The Retreat has never refused admission to married women. In its practice it has kept strictly within the restrictions of the endowment through the charity of which it was founded and by which it is maintained. There has never been any attempt at that species of legerdemain which characterizes the management of some institutions to divert the charity of the institutions into other channels than those intended by the founder. The affairs of the institution in all their details receive the attention of the Directors who are cultured, honorable men from the body of the community, representative of varied business interests and many of them actively identified with other important charities.

Hundreds of unmarried women have applied for admission, who under the requirements of the endowment had to be refused and referred to other institutions. Both from professional and humanitarian motives. I should have been glad to have admitted these greatly-wronged and unfortunate women, but neither the directors nor I had any election in the matter. From a health-standpoint these unmarried women were greatly preferable, as patients, to very many of the married ones admitted. Many of the married ones coming within the charity were poor, wretched, badly-fed and meagrely clothed. Many of them coming out of dense communities, narrow impoverished environments, a poisoned atmosphere, had been neglected and beaten by drunken and beastly husbands, so that they possessed but little stamina, mental, moral or physical with which to encounter the perils and endure the sufferings of maternity.

The Preston Retreat is the only maternity where patients are cared for the same length of time, six weeks, thus adding four weeks to the time of other maternities, and further adding to the time within which death might occur from puerperal or other causes, and thus increasing the statistics of the mortality of the institution. We feel that we are not claiming too much, when we say that the Retreat under the policy of its Directorship has exerted a wide, extending and greatly beneficial educational influence. It has been visited by physicians of every civilized foreign country, and by many eminent representative physicians of every state of the American Union. The object and motive of these physicians was to study the plan of building, sanitary arrangements, and methods of management, and the verdict of all has been gratifying. There is yet another educational feature associated with its managemen one that cannot be otherwise than far reaching in happy results, that is the thoroughness with which nurses are trained for their responsible duties. The trained nurse is fast becoming as important a personage in the lying-in chamber as the physician. The demand is for cleanliness, intelligence, the very best and most thorough training in all the many qualities essential to the successful nurse.

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### Treatment of Pleurisy.

℞ Guaiacol pure..... ʒj.
Tincture of iodine..... ʒvij.

Paint the whole of this liquid each evening on the affected side. The temperature quickly falls, an abundant perspiration takes place, and the effusion becomes soon absorbed.—*Med. Press and Circular.*

## SYMPOSIUM ON EXTRA-UTERINE PREGNANCY.

TRANSLATED BY M. B. WERNER, M. D., PHILADELPHIA.

SUTUGIN gives his views on the subject of abdominal pregnancy, which correspond largely with those of Mactecki, R. Teuffel, Bandl, and reporting 2 cases which came under his own observation. Patient aged 33; second pregnancy; 4th month, fell from a street car; general peritonitis; patient was 2½ months in bed. The following January, 1890, a cystic tumor of irregular form could be felt in the abdomen, reaching three fingers above the umbilicus. The small parts of the living fetus could be readily felt. In order to relieve the patient, Sutugin made an opening in Douglass' cul-de-sac, which was followed by a large quantity of blood; the opening was tamponed with iodoformized marly. The heart's action being weak, it became necessary to desist from further operation; the patient died two hours after.

*Autopsy.*—Behind and somewhat above the enlarged uterus was found the sac containing the fetus. The placenta was found attached to the posterior wall of the uterus, the right broad ligament and the deepest portion of the Douglass' cul-de-sac extending 9 cm. along the rectum. Attached to the fundus of the uterus was found a pediculated fibro-myoma. The anatomical diagnosis was as follows: *Nephritis Parenchymatosa, Hemorrhagic Acuta, Hydro-Nephrosis, Cystitis Catarrhalis, Endometritis, Graviditas Extra Uterine Abdominalis.* Sutugin sums up in the following manner: Retro-uterine abdominal pregnancy is usually interrupted early by the formation of hematocele; in very rare cases the gestation may go on to term. The early stages of abdominal pregnancies always have their beginning in the uterus. The symptoms of compression of the intestines and uterus appear earlier than in the other forms of ectopic gestation. Aside from the usual uncertain symptoms of pregnancy, examination will disclose a compressible swelling located behind the uterus, that organ itself being enlarged and displaced anteriorly. In the second half of pregnancy there will be found a round, irregular cystic tumor in the abdomen, in which may be felt the small parts of a fetus. Of importance diagnostically is the diminution of the vaginal canal, produced by the mass felt posteriorily giving to the examining finger a sensation of placental tissue. The cervix is usually high and sometimes out of reach. Therapeutically, Sutugin concludes, that when rupture of the sac takes place with hemorrhage, an early opening in the posterior vault of the vagina, laparotomy with complete removal of placenta is indicated.

2. MANDELSTAM reports the following case. Patient aged 24; had previously given birth to one child; not pregnant for 4 years; had been treated during that time for uterine disease. Last menstrual period occurred in the latter part of March, 1891. First of May, collapse, expulsion of the decidual membrane. A tumor could be felt to the right of the uterus. This increased up to the middle of July, to the size of about two fists and was adherent December 31st. There was found a round tumor in the middle of the abdomen, extending 2 fingers above the umbilicus. This was strongly attached to the uterus. In the early part of that month, motion had been felt by the patient. Early part of February there was considerable pain, accompanied by fever 39.5° C.; laparotomy performed February 9th; removal of the dead fetus with its ovisac; it was 39 cm. in length. The free portion of the tumor, after being thoroughly ligated, was removed; recovery complicated by pneumonia. Mandelstem further reports the histories of 11 cases, which have come under his notice during the last eight years. He advises the expectative method of treatment, even if rupture has taken place. Quoting his own words, he states, "that in the majority of cases with absolute rest, strict diet, the use of ice and opium in large doses, hemorrhage can be controlled."—ED(?).

3. MAUERHOFER reports the histories of 4 cases operated upon for ectopic gestation, observed by him in the Frauenklinik, at Berlin since 1878. He advises operative procedures in the first half of pregnancy, performed under aseptic precautions with the aid, if necessary, of tamponing the pelvic cavity. He regards this treatment as the safest even in the most unfavorable cases. Injections of

morphine in the ovisac or the application of electricity is neither used nor advised.

In the second half of pregnancy, if the fetus is living, the latter should receive some consideration so long as it does not interfere with the actual health of the mother. The time for abdominal section being left to the judgment of the physician. If the fetus is dead it is necessary to await the obliteration of the placental circulation, provided sepsis or internal hemorrhage does not make it imperative to perform an entire section.

The tamponade of the small pelvis is considered by him a great advance, since many cases in which it becomes impossible to remove all the placental attachment, one has the seat of such regions at their command for constant attention.

4. MURET describes three cases of tubal pregnancy in the early months, observed by him at the Strassberger Frauenklinik.

CASE I. Tubal pregnancy of the right side, rupture at the end of the first month, hemotocele, carcinoma of the portio-vaginalis. Total extirpation of the uterus, with its adnexa and the hematocele on right side.

CASE II. Tubal pregnancy of left side, rupture of the tube in the sixth week, hematocele, salpingectomy and enucleation of the hematocele.

CASE III. Tubal pregnancy of right side, rupture at the end of second month; tubal mole, hematocele and salpingectomy.

Muret concludes his remarks as follows:

It is important to decide between the complete or partial rupture and expulsion from the tube. A partial escape of the product of conception may result in the tubal mole; the complete escape usually results in the formation of hematocele, which usually ends in the various known complications. In cases of complete tubal abortion, the symptoms of acute internal hemorrhage are less than in the cases of ruptured tube, although some cases have been known to show symptoms of profound shock.

In cases of incomplete protracted abortion, the hemorrhage and destruction of the ovum, frequently leads to the formation of a mole. The hemorrhage, which has taken place into the tube will find its way through the open end of its fimbriated extremity, and thus lead to the formation of a hematocele. As long as the degenerated ovum, or a portion of it, remains in the tube, it predisposes to occasional hemorrhages, in precisely the same manner as in a protracted uterine abortion.

The tubal walls are frequently found quite thin at the place of attachment of the mole and the degenerated ovum, even though the ostium abdominalis is patulous. This thinning is explained by a local distension of the wall in consequence of the hemorrhage. These cases have but one method of treatment, which solves itself down to the removal of the tube. This can only be done through the abdomen, and should never be attempted through the vagina.

5. GRÆFE. Multipara, 37 years. Diagnosis first made was of a pregnant retroflexed uterus of two months, with beginning abortion accompanied by pelvic peritonitis. Later a cystic tumor was found in Douglass' pouch, not connected with the cervix; there was discharge of decidual shreds. This led to a change in the diagnosis to extra-uterine pregnancy of two months. There was sudden collapse of the patient without previous warning. A large retro-uterine hematocle could be felt, no doubt originating from the hemorrhage produced by the rupture of the tube. On the following day, laparotomy, ligation and removal of the tube. Owing to a continuous bleeding in Douglass' pouch, a tampon of iodoform gauze was placed, the end of which was allowed to pass out through the abdominal wall. Drainage soon ceased, and there resulted a collection of pus in the space posterior to the uterus, which evacuated itself through the lower angle of the abdominal wound. A longer drain was inserted, and later, drainage was made through the vagina. The patient made a good recovery.

Graefe concludes that the formation of hematocele following a rupture from an extra-uterine pregnancy, during the early months of gestation, will in no wise insure against the possibility of another hemorrhage into the abdominal cavity, and though even this should not be the case, it usually takes a long time for the absorption of a hematocele, the patient being a sufferer throughout this period, not alone from the presence of the hematocele, but from the pre-existing diseased appendages.

Bearing all this in mind a radical operative interference seems not only the most justiable, but also the most promising to the patient.

6. DOBBERT reports various anatomical investigations. He has studied numerous specimens and concludes that in cases where an abdominal section becomes necessary, the method of Dombrowski is the best. Dombrowski reports 5 cases in the year 1892, treated in this manner for retro-uterine hematocele; 3 out of 5 were directly traceable to tubal disease. Dombrowski's method is as follows: An incision is made into Douglass' pouch through the vagina, which is extended up to the sac of the hematocele; the vagina is tamponed with iodoform gauze. The patient is then placed in the Trendelenberg position, an incision made in the abdominal wall through the linea alba. If the tumor is not adherent to the parietal peritoneum, it is drawn up and the sac attached to the abdominal opening by means of sutures. The contents are then removed, and the sac cleansed; the vaginal tampon is now removed; by means of forceps, a long drain of a gauze is passed through the abdominal wound down to Douglass' pouch and out through the vagina. An additional tampon is placed in the floor of the cul-de-sac. Closure of the abdominal wound down to the tampons. Tampons are removed as often as necessary, their length being guided by the size of the opening; the vaginal drainage lasts the longest.

7. HERZFELD reports eight tubal pregnancies occurring during three months at Schauta's clinic. All cases were operated on by abdominal section with but one death, due to suppurative peritonitis. The etiology of extra-uterine pregnancy was traced in all cases to chronic and inflammatory changes of the uterus and its appendages, primarily due to gonorrhœa or previous puerperal inflammation. Four were traced directly to gonorrhœa, and two to previous pelvic inflammation following labor. Among the eight, two were primapara, one was infected by gonorrhæa, the other complicated by large fibroma. In the six remaining cases the interim between the last conception and the present was respectively fourteen, eleven, ten, nine, seven and five years. This was of especial interest, since the possibility of conception was present in each case. In two cases the period of pregnancy was completed; in one the operation was performed eleven months after supposed conception; in the remaining cases the period of pregnancy ranged between six and eleven weeks. It is of importance regarding diagnosis to bear in mind the difference in the growth of the uterus between ectopic and normal gestation—the uterus developing more in length than width in the ectopic variety. The question, however, becomes more difficult between the extra-uterine and the pregnancy in the uterus unicornus. The author, however, calls attention to the position of the ligamentum uteriteres, as an aid in differential diagnosis.

HERZFELD closes his remarks by giving a careful description of Schauta's method of operation done under strictly aseptic conditions. While it is always desirable to remove the entire ovisac, it often becomes a dangerous proceeding. In the latter case he usually desists in performing a radical operation, uniting the sac to the lower angle of the wound, and drains. Two such cases are reported, in both the fetus was dead.

8. ZEDEL has presented four specimens of tubal pregnancy, having made a careful histological and microscopical study of each. The ovum was imbedded in the tube. The epithelium in the ovisac was flattened, due, in all probability, to pressure. Generally, there is no complete decidual change in the tubal mucous membrane, only a portion being found near the insertion of the ovum. A complete development of the decidua vera being rarely met with. The upper layer of the serotina can be traced to the lower layer of the ciliated epithelium. The decidua tubaria originates principally from the perivascular connective tissue found in the mucous membrane. The author has been able to demonstrate the connection between the arteries and veins and the intervillus space in a tubal pregnancy of fifth week. The loss of the connective tissue and muscular layers and the incident changes following the cell proliferation of the intima, materially favor the increase of blood supply. This latter is, to his mind, the cause of breaking down the serotina and establishing the communication between the lumen of the blood vessels and the placenta.

The author arrives at the following conclusion: that in the beginning of the

fifth week, the intervillus circulation establishes itself, and fetal life is nourished by the maternal blood. The other points in the circulation are the same in tubal as in intra-uterine pregnancy. A decidua reflexa forms in the tube, and is for the development of the ovum until the intervillus circulation has been thoroughly established. Fibrous layer originates not only from the upper layers of the decidua materna, but also from the neighboring structures, the cellular layer of Langhans. The placenta consists of the original villous chorion, and the superficial layer of the decidua. The development of the ovum proceeds in the same manner as in the uterus.—*Schmidt's Jahrb*, No. 9, 1893.

## DYSMENORRHŒA—ITS CAUSES, SYMPTOMS AND EARLY TREATMENT.

M. F. DeHART, M. D. Jersey City, N. J.

In these days when preventive medicine is the favorite theme of all the most scientific physicians, when such thorough investigations are being made into the causes of disease, and all agree that it is so much easier and better to avoid sickness than to effect the most brilliant cures, it seems strange that so little is said on this subject, which is the cause of so much suffering and the first symptom of so many serious life-long diseases which require at last, the entire removal of the uterus, tubes and ovaries to allay pain and restore peace, which unfortunately, even then the patient does not always find until she folds her hands in death.

One reason for this undoubtedly is that women bear this oft-recurring pain without complaint for many years, as they have been taught to look on this as one of the misfortunes of their sex and inevitable. Their mothers, often having had the same trouble, do not look on it as anything alarming, and so content themselves with giving hot drinks, ginger tea or gin, until the pain has worn itself out for that time, but only to return with increasing intensity at the next menstrual period. This from being an occasional occurrence soon becomes a fixed habit, and is looked forward to with dread from month to month.

As it has been so gradual in its progress, no one realizes how strong a hold it has taken, or how much it has undermined the general health, causing nervousness, dyspepsia, and a long train of mental symptoms, which are as much a part of the disease as the pain. Women hesitate for a long time before consulting a physician, fearing that an examination will be necessary or an operation suggested. Some complain that physicians are indifferent to these early symptoms, and make light of this pain, assuring them that it is nothing serious; that all women are the same, and that they ought to marry, which will, no doubt, cure them; or content themselves and pacify the patient with a prescription of morphine, to be used when required; that others, going to the other extreme, advise an operation for every case without trying the effect of medicines or suggesting hygienic measures, which might in the early stages be sufficient for a cure.

In this way the years run on until this once slight functional disturbance has drawn everything into the tangle, and every organ sympathizes, adding its quota to the general misery, so that it is difficult to tell what is cause and what effect, or to know where to begin to unravel the snarl and restore harmony to the disturbed economy.

Listening to the long array of symptoms, and noticing this gradual advance and steadily increasing intensity from month to month, and from year to year, one is forced to ask, "Why did you not come long ago," and "Was there no one with common sense enough to tell you that menstrual pain was *never* natural, but on the contrary, like all other, always a signal of distress," "To notify you that something was wrong, that it was not enough to stupify one's self with anodynes before learning the truth it was sent to announce, and that enduring it with patience was no virtue until an energetic effort had been made to find out the cause and remove it, after which there would doubtless be ample

opportunity to develop this admirable Christian grace."

Among the causes which bring about this unfortunate condition we shall find everything that tends to lower the general health,—indoor life with too little light, air and sun, too little general exercise, and too much persistent use of a few muscles, as in dancing, sewing on a machine, or long standing in stores—too little legitimate occupation for the mind and too much stimulation and excitement of any unhealthy kind causing loss of sleep—imprudent exposure to cold at any time and especially during the menses–irregularities and improprieties of diet causing constipation and general disturbances—senseless and absurd clothing, which is too heavy and too tight about the waist and not evenly covering the body, leaving many parts too much exposed and others overburdened—long unyielding corsets which interfere with free natural movements of the body, pressing the abdominal organs downward and holding the uterus in a cramped and uncomfortable position.

At first the pain is only for an hour or two, either before the menses appear or just after, but if unrelieved, it becomes more severe and lasts longer each month until the premonitory pains occupy the whole week previous to menstruation and the following week is required to recover from its effects, thus three weeks out of the month are given up to this function which should be painless, and no more disturbing than digestion or respiration. This condition prevents exercise, interferes with all work, study and amusements, leaving its victim a chronic invalid shattered in mind and body, of no use to herself and a burden to others. Is it any wonder that she is a prey to whims and fancies—that she aggravates her real sufferings by many that are purely imaginary, thus wearing out the patience of friends and wasting her own life?

It seems scarcely reasonable to suppose that all this trouble can be cured by any one operation however radical, for her whole nature is involved, and she is a wreck physically, mentally and sometimes morally—her will-power is destroyed, and there seems to be no place to begin the work of cure, for medical science is, as yet, often powerless to avert the penalty attached to violated natural laws.

In view of these facts, and I think that any one who has had much experienec with these cases will admit that they are not overdrawn, is it not the part of wisdom to instruct women on this all-important subject, not waiting until irremediable evils have rendered advice and treatment well-nigh useless? Would not a wise preventive treatment be followed by as good results here as in typhoid fever or septicæmia, and can physicians feel that they have done their duty to the families under their care if they have not endeavored to educate them on this subject as well as on other truths of hygiene?

In the early days, a thorough change of habits with careful regulations of the bowels, and Assafœtida gr. iv, three times a day for three days before the expected period, and Assafœtida gr. viij, xii, three or four times during the first day, will often give speedy relief, and if continued for several months will many times effect a permanent cure.

This simple prescription for so formidable an array of symptoms, may seem to many as absurdly inadequate as the old-time advice given to the leper by the prophet to wash in the river Jordan—but simplicity is said to be the height of art, and success is a sufficient answer to all objections.

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### A Prolonged Fast.

There is reported from Russia a case of unusually long fasting. A young girl of seventeen was overtaken by night near the village of Ruzino in Moscow on the 24th of last November. She took refuge under a small outbuilding covered with straw. During the night it snowed violently, and in the morning the girl was unable to force her way from under the snow. The first day she ate five bits of bread she had with her, after which she had no food but the snow. Fifty-one days later she was discovered buried under three feet and a half of snow. On being taken to the hospital on January 14th, she was in a state of extreme exhaustion and unable to move a limb, though entirely conscious. There was a general cutaneous anasarca. The mucous membranes were excessively pale, and there was no trace of panniculus adiposus. The muscles were much atrophied. The respiration was 26; the pulse 84, small and feeble; the temperature 38° C. For the next two days she remained semi-conscious and somnolent, but rapidly recovered, and at the end of a week was able to take hospital diet.—*Ex.*

# SOME POINTS OF INTEREST TO THE MEDICAL PROFESSION.*

SENECA D. POWELL, M. D., New York.

In accepting the Presidency of the Medical Society of the County of New York, with the duty and responsibility of presiding over the deliberations of a body so justly renowned and influential, I cannot but be sensible of the honor bestowed and the confidence expressed by your selection. You have my thanks; and I hope that I may be able so carefully and impartially to discharge the duties of the office that your confidence will be justified.

I yield to no one in appreciation of the dignity of this organization, and the importance of its influence. It is the ancient and legally recognized authority upon professional standing and medical ethics. The size and character of its membership, with its location in this cosmopolitan city, make it a power in our profession, perhaps, unequalled by any like association in this country. Its spirit is contagious. Its deliverances are esteemed as professional oracles. Its efforts towards any object carry the prestige, power and effectiveness, which naturally pertain to a body of men distinguished for the highest professional knowledge and success.

Such being the case, a certain leadership belongs to this Society, which cannot be refused. It is expected—in a sense demanded of us. The position is ours, and its responsibilities cannot be properly ignored; nor can the duties of such leadership be safely neglected. It belongs to this Society to take the initiative in the correction of abuses where discovered, and in the introduction of real improvements.

## MORAL EQUITY AS BETWEEN PROFESSIONAL BRETHREN.

To this end you will permit a question or two, not inappropriate to the occasion, and which I heartily commend to your good judgment and enlightened professional conscience. My first point is not so much a question of legal justice, but rather a matter of moral equity as between professional brethren, and especially as between two classes with unequal opportunities and rewards. Of course it belongs to us to lead the medical profession in the adoption of all measures calculated to secure to every member full legal rights; but quite beyond this, I think it will be conceded, that upon the more favored and successful practitioner rests a special moral obligation to see that no procedure of his works an injustice, or is occasion of needless embarrassment to his less fortunate brethren. I am satisfied that such injustice and embarrassment is occasioned by the readiness of the communities to abuse opportunities for free treatments, together with the indifference of many physicians, and their failure to investigate and to discriminate in such cases. It is not my thought to check a real benevolence. I would be the last man to deny the reliefs and benefits of science to the poor. It is a glory of this city, that no one, in whatever extremity of poverty, needs to perish or suffer for lack of prompt and skilful medical attention. But the policy, or at least the practice, of many dispensaries and hospital associations, puts a premium on meanness; and withdraws from the local practitioner his natural clientage, by compliantly serving at the free dispensary those who are abundantly able to pay for what they receive. Not only so, but to appease an uneasy conscience, a nominal fee is asked and given, and further moral obligations are lost to view. This is in fact abetting fraud. It is an outrage upon public confidence, as well as a very palpable injury to a large class of practitioners. Our leading physicians and surgeons connected with these charitable institutions are more or less responsible for this state of things. We freely admit that the case presents some difficulties, but surely new rules, or more conscience, care and discrimination are demanded. A most public and flagrant instance is furnished by the Board of Health in its recent crusades of wholesale vaccination. There is, perhaps, little to be said of the work in Cherry street and the like; but when it comes to the free vaccination of the employes of prosperous business houses and rich corporations, and even of the sleek moneyed men of the Produce, the solidated, and the Stock Exchanges, and

* Inaugural address before the Medical Society of the County of New York, by the President.

the Board of Trade, the preposterous extent of the abuse and the consequent professional injury in seen at a glance. Such things could not occur did not physicians lend themselves to the scheme. I should prefer to believe it was done thoughtlessly; and I trust that a declaration on the subject by this Society would do much toward correcting such abuses.

Again, whenever a man puts a low estimate on the importance and value of his own service, he so far lowers the medical standard, and thereby injures his professional brethren. Why reputable physicians should consent to serve rich corporations for nominal returns, would seem hard to explain. But the anomaly exists. Many illustrative instances of these misplaced favors will occur to the minds of these present. In this regard the legal profession sets us a different example, and one worthy of our emulation. So far from belittling the importance of his own service to the injury of his own profession, the corporation lawyer exacts the highest fees, and those commensurate with the interests involved. Why should the physician adopt an opposite course?

### ON EXPERT MEDICAL TESTIMONY.

Another point to which I would call your attention is the matter of expert medical testimony in the courts. Comparatively recent events in connection with some trials of peculiar public interest have given this subject especial prominence. My impression is that the result has been to discredit the value of the expert testimony as a whole. It is evident that in the case of conflict or apparent discrepancies between the testimonies of reputed experts, neither the public, the ordinary jury, nor indeed the bench of judges, nor the bar, have the especial training which would qualify them to discrimate between true and false, and duly to estimate the scientific value and the proper influence of the facts in a given case. The result is to create an impression of vagueness, a natural distrust of the whole business, and of the medical science with which it is associated. Such a matter at first thought might seem beyond the power, if not the province of this Society. But permit me to suggest that it is not really so. Both in the interest of civil justice, and of our profession, the evil might be rectified by the appointment from this Society of a commission or jury of competent physicians to review and to pronounce upon the entire expert testimony in each given case. The summing up by such a commission would in the highest degree inspire confidence and subserve the ends of justice. Of course such a procedure must be authorized by Statute law. But it is entirely within the province of this most influential body to propose and to secure the appropriate legislation.

### ON MEDICAL LEGISLATION.

And this brings me to another very important consideration affecting our relation to the profession at large, the State and the community. It is an undeniable principle that with a responsibility of any sort must go the power and supervision in the matter under consideration. Now since this is the legally instituted and recognized medical society of the County of New York, and the body in which inheres the major responsibility for whatever action may be taken affecting medical affairs, it follows that all legislation relating to the practice of medicine, either as between physicians, or between the physician and the community, should be first admitted to this Society and receive its approval or disapproval before it is transmitted to the State Society or proposed for enactment as a law. A Society of such a character as this is often asked to endorse plans and schemes which may be worthy of its endorsement, or possibly should not receive its sanction. In my judgment *all* such propositions should be referred to the *Comita Minora* for careful consideration before any official action is taken, and I so recommend.

In view of all that has been said upon this subject and of the necessities of the case, the propriety must be manifest to everyone of adding to our standing Committees one on Legislation, to the especial care of which may be committed all such matters, often among the most important upon which we may be called to take action.

### A CASE OF OFFICIAL DISCOURTESY.

A recent case of official discourtesy and injustice I think worthy of mention in this place, not so much on account of its intrinsic character, as in view of what appears to me a want of proper *espirit de*

*corps* and professional sympathy in the treatment of the affair by some of our physicians: Referring to the case of the New York Infant Asylum, it is noted in the issue of the *Medical Record* of November 25th that, "A recent attempt to bring before the medical profession the question of the treatment of Medical Boards by the managers of hospitals, provoked unfortunately, a somewhat sharp discussion at the Academy, and showed again how quickly a number of physicians will side with the higher and the moneyed powers and against their medical brethren."

The facts of the case entirely justify the remark, which I have quoted from the *Journal*. It is indeed an unfortunate state of affairs, not that the atmosphere of the Academy should be stirred by a sharp discussion, but that physicians should be so short-sighted, not to say partial and unjust, as to range themselves upon the wrong side of such a controversy. By all accounts the course of the Board of Managers was arbitrary, ungrateful and discourteous in the extreme to the Board of Physicians, who had long given the institution without reward, and as it now appears without thanks, a valuable service in the frequent rendering of their professional care, and by their advice as to competent men for visiting physicians. Upon what ground such discourtesy to such men can be justified it is hard to see. But my especial point is, that, is if we do not sustain honorable brethren of our own profession in their expectation of just and courteous treatment, we injure and degrade the profession itself. A certain jealousy for professional rights and honor is certainly due from every member of the fraternity; and every failure in this regard not only reacts upon ourselves, but is an injury to all.

SECTARIAN DESIGNATION.

Perhaps a mere allusion may not be out of place to the attitude of some, who are not unwilling, to say the least, that an impression should go abroad that they are practitioners of sectarian medicine. If a word to the wise is sufficient, it should only be necessary to recall the positive attitude of our Society upon this subject, and its unmistakable declarations. Article XVII of our Constitution reads: "No member of this Society shall assume any sectarian designation indicating that his practice is based on any special doctrine or dogma, or specified method of treatment." And again, the closing sentence in the form of application for membership reads: "And (I) hereby declare my abnegation of sectarian principles and practice." The moderate and conservative thought is, that the County Society means just what it so emphatically proclaims, and that the only proper and just course is to receive gentlemen as members, when all the requirements for membership are complied with.

ON INCREASE OF MEMBERSHIP.

In closing let me express some sense of the pleasure and profit personally derived from my connection with this Society in the past, and my desire for its present and future importance and usefulness. To this end I ask that the present members have in mind the thought of increasing our membership by the introduction of proper candidates; and that from the older members especial consideration be shown for the young men of the profession, both within and without the Society. Such encouragement is often of great value to the recipients, and the young blood is essential to the health and growth of the organization.

I further crave your consideration and assistance in my efforts to facilitate the business and to promote the interests of this body in the honorable and responsible position in which you have placed me.

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**Purpura of the Newborn.**

Glenn (*Transactions of the Royal Academy of Medicine*) reports the case of a first child of healthy parents; no history of syphilis, child asphyxiated when born. At birth the infant was covered with discrete hemorrhagic spots, especially on the face, chest, and back. On auscultation a loud bruit was heard over tricuspid area. The child lived thirty-six hours. On post-mortem the spleen was found much enlarged and of a deep red color, weighing forty-five grammes. Liver enlarged, deeply stained with bile and firm to the touch. Kidneys, with the exception of a few superficial hemorrhages, were normal. Stomach and intestines were covered with purpuric spots similar to those on the skin. Both visceral and parietal layers of the pleura were studded with hemorrhages, the same condition being found in the pericardium. Foramen ovale open. All the remaining internal organs were hemorrhagic.—Ex.

# EXCISION IN THE TREATMENT OF SPINA BIFIDA.*

JOHN B. ROBERTS, A. M., M. D., PHILADELPHIA.

The unsatisfactory results which are believed to follow operative treatment of spina bifida have induced the profession to largely refrain from active measures in the management of the condition. A most conservative view is found in *Stephen Smith's Operative Surgery*, which the author attributes to Holmes, but seems to fully endorse. He says: "No case of spina bifida ought ever to be subjected to any active operative interference, except in the most urgent circumstances, and the mildest measure which affords any rational prospect of cure should be the one selected."[1]

The Committee of the London Clinical Society, consisting of Messrs. Howard Marsh, A. Pearce Gould, H. H. Clutton, and Robert William Parker reported in 1885 "That the evidence was conclusive that a large proportion of specimens of spina bifida the spinal cord is within the sac;" and that the committee was not acquainted with any means by which it was possible to determine in the living subject that the spinal cord was not in the sac. For this reason the committee believed "that any operation involving interference or removal of the *median vertical portion* of the tumor should be entirely abandoned." This statement was made notwithstanding the fact that the members of the committee were "quite conscious of the large measure of success that has attended the operations of ligature and excision, but we cannot lose sight of the fact that these operations always expose the patient to the grave dangers attending removal of the expanded spinal cord and attached nerves." After an extended examination of specimens and of the literature of the subject, this committee came to the conclusion that the plan of treatment by injection with iodine, iodide of potassium and glycerin, recommended by Morton, was the best with which its members were acquainted, and was the only one which they felt justified in recommending.[2]

Cabot at a recent meeting of the American Surgical Association states[3] that Treves is of the opinion that operative treatment of bifid spine "can only be undertaken in those comparatively infrequent cases where the sac is quite free from either the cord or any of the spinal nerves," and that "if the sac contains cord elements, result will prove fatal." J. William White wrote, in 1891, that he believed that most surgeons agreed with the opinion that injection with the iodo-glycerin solution is the best method of treatment.[4]

It is not surprising that such expressions as those should have deterred surgeons from attempting excision in spina bifida. It is because I find myself obliged to dissent from these opinions that I recently operated upon a case which I desire to record. A consideration of the circumstances surrounding the fatal issue of my own case and the study of surgical literature have pretty thoroughly convinced me that in properly selected cases excision is not only justifiable, but will be found satisfactory in relieving the patient from the disability due to the congenital defect.

The importance of undertaking active treatment in bifid spine is shown by the record of 647 deaths from this congenital condition in England in the year 1882. Of these deaths 615 occurred while the patients were under one year of age.[5] The fatality of the affection is well illustrated by this record, and is a piece of evidence whose value is not broken by the 13 cases of spontaneous cure found by the London Clinical Society Committee after a laborious search in surgical literature.

Occasionally patients with spina bifida may reach adult life, as in the unusual patient mentioned by Callender, who had attained the age of seventy-four years.[6] The Clinical Society Committee found 13 cases, who were living at, or who had, before death, attained ages varying from nine to forty-three years. Mr. Clutton operated successfully by excision on a lady aged twenty-four years.[7]

* Read before the Academy of Surgery, 1893.

1 Edition, 1887, p. 360.

2 Trans. vol. xviii, 1885, pp. 383, 385.

3 Annals of Surgery, August, 1892, p. 122.

4 Trans. American Surgical Association, vol. ix, 1891, p. 133.

5 Trans. London Clinical Soc., vol. xviii, 1885, p. 339.

6 Ashhurst's Principles and Practice of Surgery, Ed., 1893, p. 719.

7 Sajous' Annual of Universal Medical Sciences, 1892, p. A. 50, from London Lancet, October 10, 1891.

These unusual instances of longevity, notwithstanding the existence of such a perilous condition, do not invalidate the evidence of the great infantile mortality shown by the statistics in England alone during 1882. From what I have said it would seem that the two methods which the surgeon should contrast are injection by the iodo-glycerin solution and excision. The Clinical Society Committee collected 71 cases treated by this injection; of these 35 had recovered, 27 had died, 4 were relieved, and 5 were unrelieved. Dr. Morton, the advocate of this injecting material, had informed the committee that of 50 cases so treated 41 seemed to have been successful. I presume that some of the cases in the two lists were the same patients. The same committee collected reports of 23 patients treated by excision of the sac, of whom 16 recovered and 7 died. Ashhurst states[8] that the statistics collected by that committee and by Dr. C. A. Powers show that of 86 cases treated by the injection method, 50 were benefitted, and of the 57 cases treated by excision, 40 cures resulted. Dr. Powers' paper is well worth careful reading, and will be found in the *Medical Record*, July 16, 1892.

The injection of the sac seems to me so unscientific, because it is really groping in the dark, that I am impelled to the conclusion that incision,exposing the contents of the sac, followed probably by excision, is the preferable method of dealing with bifid spine. This conclusion is confirmed by the results attained by myself and others in many operations upon the brain and spinal cord. An aseptic wound of these organs, under ordinary circumstances, seems to be comparatively safe. Operative treatment, therefore, of spina bifida under modern methods must be considered in a rather different light from that of five or six years ago. I agree almost perfectly with those who consider excision a satisfactory and proper operation, even though it be undertaken in children but a few weeks or months old. Various modifications have been proposed in the endeaver to remove the tumor and close the fissure in the vertebral canal.

Two cases are reported by the Committee of the Clinical Society in which the skin was dissected from the sac and then sutured in the middle line over the tumor. I do not know of this method of operation being performed by others than the two operators mentioned in the report. Death occurred in one case, recovery in the other.

Evacuation of the fluid and excision of the sac of the tumor is the method usually meant when excision is mentioned. The dura should be divided and stitched so that the line of suturing does not correspond with the suture line in the skin. This method is especially advocated by Mayo-Robson.[9] Mr. Mayo-Robson in one case inserted a portion of periosteum, taken from a rabbit, over the closed meninges; and carefully sutured it to the periosteum of the laminæ on each side of the cleft. No bony formation resulted from this transplantation, though the periosteum taken from the rabbit evidently preserved its vitality. In one of his cases, cure was accomplished even after suppuration had occurred in the sac. The operation consisted in complete removal of the sac with efficient drainage. Of the four cases operated upon by him, three recovered. This operator also suggested bending the neural arches toward the middle line and uniting them with silver wire in the endeaver to make a bony wall to the defective spinal canal.

Osteoplastic operations similiar to the method proposed by Mayo-Robson, but not used by him, have been performed successfully by J. Dollinger,[10] of Buda Pest, by Zenenko,[11] of St. Petersburg, and by Rochet.[12] Berger[13] operated successfully on a child seven weeks old, by transplanting a piece of the scapula of a rabbit, and Bobroff,[14] performed an osteoplastic operation, taking a section of bone from the crest of the ilium of the patient to fill the gap in the sacrum.

Rochet states that the structures resembling nerves traversing the sac are not always true nerves and have no physiological function. They can be cut or exercised without special harm being done to the patient. He says that Bellange reports 11 cases in which nerve filaments of various sizes were cut during operations without any paralytic or anæsthetic phenomena resulting. This observation made my other observers is said to be the rule.

8 Principles and Practice of Surgery, Ed., 1893, p. 719.

9 Trans. London Clinical Soc., xviii, 1885, p. 218.
10. Annals of Surgery, September, 1887, p. 168.
11. Annals of Surgery, September, 1889, p. 223.
12 American Jour. Med. Sciences, October, 1893, p. 477.
13 Am. Jour. Med. Sciences, October, 1893, p. 478.
14 Annals of Surgery, September, 1892, p. 270.

The securing of a vertebral canal by some osteoplastic procedure would seem to be a very desirable addition to the original operation by excision. I do not know how much better the condition of the patient is, however, after such attempts at securing a bony closure of the gap. Theoretically, it would seem desirable, but many cases have been satisfactorily cured by operation, in which removal of the sac and simple suturing of the skin over the gap in the bone were done. The bone to be used for closing the gap may be obtained as in the operations recorded, or, as suggested by Bobroff, from one of the ribs when the bifid spine exists in the dorsal region. De Ruyter, of the University Clinic at Berlin, has made an interesting study of the question of excision in the condition under consideration.[15] He believes that cases of meningocele are usually proper ones for operation, but of meningomyelocele, only those are suitable for operation in which the proportion of the essential elements of the cord involved in the cyst wall is small and derived from a point below the sacral plexus. He excludes from operation all cases of this class in which the nerves given off from the spinal cord, lying in the median line, pass to the cyst wall and thence to the inter-vertebral foramina. He also excludes from operation all cases of myelocystocele because these cysts are usually small, the skin covering them sound, and the patient's condition about as good as it would be after operation. He gives some suggestions for diagnosticating these varieties of spina bifida, and considers a puncture or exploratory incision justifiable for diagnostic investigation previous to operation. Of eight cases treated by surgical operation in the Berlin Clinic during the time over which his study extended, five died.

Hildebrand, of Göttingen, at the meeting of the German Surgical Society this year, presented a careful study of 27 cases of bifid spine and showed that the cleft may involve the bone, dura pia, cord and the over-lying soft parts, or only one or two of these structures. He reports 13 cases operated upon in the Göttingen Clinic, of whom 10 were discharged cured. He advocates operation on all varieties of spina bifida, excluding only those in which there is a marked degree of paralysis.

I have made no attempt to collect cases of bifid spine treated by excision. The operation has probably not been done very often in America. Cabot,[16] of Boston, Hayes,[17] of Rochester, and Hurd[18] have reported cases. I add the clinical record of a case recently operated upon by me which terminated fatally.

A male child, fifteen days old, was seen by me on September 25, 1893, at the request of Dr. Isaac W. Hughes. The child was exceedingly healthy and well formed, except a bifid spine. The prepuce was, however, adherent, though no true phimosis existed. One of the legs showed some lack of power, but their sensation I did not test. The contents of the rectum and bladder were evacuated at ordinary intervals, though according to the statement of the nurse, there was a tendency to dribbling of urine nearly all the time, and some slight leakage from the rectum when the baby strained. It is possible that thsee were evidence of a want of control of the sphincter due to condition of the spine. The infant nursed well and cried very little, showing its extremely healthy and comfortable condition. The tumor due to the congenital deformity occupied the upper portion of the sacrum. It was hemispherical and measured about an inch and a half vertically and horizontally, and was elevated above the surface of the back about one inch. The central portion consisted of translucent tissue upon which was an ulcerated-looking space toward the lower portion of the tumor. This granular or ulcerated condition was present at the time of birth. The normal skin extended up the tumor on each side to a sufficient extent to leave only about half the surface of the hemispherical swelling of translucent tissue. The mass fluctuated on pressure and seemed to increase little, if any, when the child cried. Under the circumference of the tumor on each side could be felt a hard edge which seemed almost like bone, but which was evidently the margin of the muscles of the back or the posterior border of the iliac bone on each side.

15. Annals of Surgery, September, 1890, p. 296.

16 Annals of Surgery, August, 1892, p. 121.

17 Ashhurst's Principles and Practice of Surgery Ed. of 1893 p. 720.

18 Therapeutic Gazette, October 1, 1889.

The parents of the child were given an unfavorable prognosis and an operation by excision advised. Accordingly, I cut away the mass on Wednesday, September 27, 1893. Corrosive sublimate solution was used for the sponges and for sterilizing the surface of the child, but the instruments were kept in betanaphthol solution after having been sterilized by heat. Ether was used as the anæsthetic.

A puncture was made on the right side of the tumor above the margin of the skin, and about two drachms of colorless fluid allowed to escape. No symptoms occurred during this evacuation of cerebro-spinal fluid. The collapsed sac was then excised by two curved incisions meeting at a point above and below the protrusion in healthy skin. Six or eight nerves were found attached to the internal surface of the translucent membrane forming the dome of the tumor. These were consequently dissected loose as close to the membrane as possible. On each side of the sacrum in front were seen similar nerves, but of larger size, entering the anterior sacral foramina. These, as well as the nerves dissected from the sac, came out of an opening at the upper portion of the sacrum which led to the vertebral canal. This opening would not entirely admit the tip of my little finger and was circular, being about three-eights of an inch in diameter. In this opening lay what I supposed to be the cauda equina, which very nearly filled the entire orifice. This bony opening was situated very close to the upper edge of the external tumor, which had been developed principally below the opening rather than over it. The dura mater was apparently adherent to the internal surface of the tumor wall. The posterior wall of the vertebral canal in the sacral region was absent below the opening mentioned. The anterior sacral nerves were not interfered with, but the posterior ones with the cauda equina, or lower end of the cord, were pushed into, but not through the bony opening by my finger tip. The youth of the child and the serious character of the operation deterred me from undertaking an osteoplastic procedure, and even from interfering with the contents of the sacral opening.

The skin flaps left by the incision of the sac were then brought together over the site of operation by interrupted catgut sutures. No drainage was used and the wound was sealed by strips of gauze saturated with iodoform and collodion. Some slight bleeding had occurred, but it was controlled without difficulty, and the sutures were applied so as to catch the vessels which seemed likely to bleed. A large mass of carbolized gauze was then applied and firmly held in place by a bandage. No ligatures had been required. The child slept after the operation and seemed to be reacting well.

The operation was completed about 3 P. M., having occupied about half an hour. In the neighborhood of five o'clock that same afternoon the nurse noticed some blood escaping from under the bandage. Attemps were made to stop this blood by pressure, without removing the dressing, but they were unsuccessful. At half-past nine I saw the child and removed the dressing, discovering that the bleeding came from a point at the upper angle of the wound, where pressure of the dressing was probably not as efficient as over the rest of the operative field. An acupressure pin was thrust through both margins of the wound and a catgut ligature wrapped around the ends of the pin in an eliptical manner. This readily stopped the bleeding. A similar pin was put at the lower angle of the wound as a precautionary measure, though it was not sure that any part of the bleeding came from that point. The upper pin was situated over the spot where the cauda equina had been pushed into the spinal opening, but was so inserted that no injury to the cauda or spinal nerves could occur. An iodoform and collodion dressing was again applied, and carbolized gauze adjusted outside of it. It is probable that the patient lost about an ounce of blood. Its lips, however, and finger tips retained their pink color, though the child looked paler than before the original operation.

I observed that the acupressure pins inserted deeply in the muscles of the back gave the baby no pain though this procedure was done without anæsthesia. It was evident, therefore, that there was a defect in the innervation of this region, as would be supposed from the nature of the congenital lesion.

Three drops of whiskey were administered about five times during the succeeding night and the following day. After the redressing the patient seemed quite

comfortable and needed no anodyne; and indeed none had been required previously. It slept comfortably, continued to nurse well, and seemed hungry.

The morning after the operation, at about 10 o'clock, the nurse observed evidences of nervous irritation shown by the head being bent backward, and some irregular muscular action of the eyes. The arms and legs, however, did not become stiff, and the baby did not cry or seem to feel pain. It, however, was very apt to start at sounds and had to be removed from a room in which a wood fire was burning, because the crackling of the wood thus annoyed it.

I saw the patient again at 5 P. M., having left in the morning about eight, before the symptoms of nervous irritation had shown themselves. Up to that time it had had eight or nine spasmodic attacks of the kind mentioned, and had taken since noon about three grains of potassium bromide in doses of one grain. This had been prescribed by Dr. Donnel Hughes, because of the evidences of nervous excitement. The nurse reported that the spasms had been less marked since the bromide mixture had been taken. Since morning the baby had refused to nurse, but had been fed with breast milk by means of a spoon. During my visit I had opportunity to observe one of these convulsive seizures. The head was quite strongly retracted by spasms of the posterior cervical muscles; the occipito-frontal muscle caused tranverse furrows in the forehead, and the ocular muscles produced by their spasmodic action an irregular and varying strabismus. There appeared to be no spasm of the extremities and no real pain, for the child did not cry.

Before the occurrence of this seizure its pulse was 160 and not very weak; its respiration 60, and its temperature in the rectum 99.8° The whiskey which it had been taking during the day, as previously detailed, was stopped, and the bromide mixture increased so that it received two grains every two hours unless asleep. No further hemorrhage had occurred.

Thursday night, September 28th, pulse, 116; respiration, 60; temperature, 98.4°. Friday morning, September 29th, pulse, 130; respiration, 59; temperature, 98.1°. The attacks of spasm ceased about 7 o'clock last evening, and were even before that time not severe. At 4 P. M. there had been no further seisures, the child had taken its medicine and milk, which had been given with a spoon, and had a good movement of the bowels. The leakage from the bowel, which had previous to the operation been almost continuous, had ceased. The baby had been taking two grains of potassium bromide every two hours during the night and to-day, and had slept well. Friday evening, pulse, 136; respiration, 52; temperature, 97.6°.

On the morning of the third day after the operation, at 2 A. M., the child had a general convulsion which was followed by four others within two hours. The arms and legs became rigid, the gums were tightly clinched, the head drawn back, and the child's face cyanosed. The spasm seemed to involve all the muscles of the trunk, and even those of the scalp and face. One grain of potassium bromide was given every hour. After a few doses the convulsions diminished in frequency and severity. A slight one occurred about half-past seven, when no bromide had been taken for about two hours. The bromide was ordered to be continued, one grain every one or two hours according to the condition of the patient; and inhalation of one drop of chloroform directed to be administered if the convulsions were prolonged or frequent. The bandage was removed; the iodoform dressing opened immediately over the head of each of the acupressure pins, and these pins were withdrawn. The small hole made in the dressing was closed with absorbent cotton sealed with iodoform and collodion. A drop of brown blood oozed through the original dressing at the spot where the upper pin's point was situated. There was no evidence of sepsis and the original dressing was unsoiled and sealed the wound thoroughly. There was no escape or oozing of cerebro-spinal fluid observable at any time during the after-treatment of the case. The temperature at this time was 98.6°; pulse, 140; respiration, 46.

On the fourth day after operation I noticed oozing of some brownish fluid from under the lower part of the dressing near the gluteal crease. At this time the child had had no convulsion for thirty hours. Fearing that the proximity of the lower portion of the dressing to the

anus would lead to contamination of the wound by the escaping fluid becoming infected, I removed the iodoform and collodion dressing, which had been applied on the evening of the operation at the time I introduced the acupressure pins to stop hemorrhage. The wound was healed by first intention, except at the upper end, where there was a small gaping of the skin and a granulating surface. Across the upper and lower portions of the wound were lines of devitalized skin, rather grayish in color, evidently due to the acupressure. No cerebro-spinal fluid was escaping at any point. I was quite certain that the tissue which had been compressed by the acupressure pins would slough, but the rest of the wound seemed so healthy that I thought I should have little trouble with further local treatment. The wound was dressed with bichloride gauze after having been dusted with boric acid powder.

The dressing thereafter was changed daily. The wound however, did not do well. After the slough caused by the acupressure pins had separated, and on the twelfth day after operation secondary hemorrhage occured from the upper part of the wound at very much the same spot from which the original hemorrhage had occured a few hours after operation. This was treated by pressure and a new dressing. Two days later it recurred and was controlled by the introduction of two catgut sutures introduced at the point of bleeding. Death occurred fifteen days after operation from exhaustion due to the hemorrhage and the septic contamination from the sloughing surface. No autopsy was obtained.

The unfortunate result in this case was almost certainly due to infection of the wound occurring during the operation or at the time or the removal of the iodoform and collodion dressing on the fourth day. At that time, as has been stated, the wound was completely united. I noticed, however, a drop of purulent-looking fluid at the opening made by one of the catgut stitches.

Whether this catgut, which I had not prepared myself, was septic, and acted as the original focus of suppuration and sloughing, I am not able to say. It is possible that in many changes of dressing some fault in technique may have happened, as on one or two occasions the dressing had to be made under difficulties. The imperfect nerve supply of the part is to be taken into consideration as a cause of lessened resistance in the tissues when sloughing and suppuration once began. I have also thought that it possibly was an error to have used boric acid powder upon the wound daily, as the irritation of this drug may have aided in devitalizing the tissues already defective in nerve supply. I used the boric acid powder because I feared that otherwise the wound not be kept dry; and that if moist, infection by fecus or urine would more readily occur to vitiate the result. Until the secondary hemorrhage took place, I thought that the patient was on the road to recovery, although his temperature was rather high and irregular, on account of the sloughing process going on in the back. He took food well, seemed comfortable, and had very few convulsive seizures, which seemed to be easily controlled by bromide of potassium internally and chloroform inhalations.

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**Danger From the External Use of Salicylic Acid.**

The *Schweizer Wochenschrift fur Pharmacie,* publishes the following: a few days ago, one of our country practitioners, who had long been troubled with sciatica, concluded to make a trial in his own case of salicylic acid, in alcoholic solution, as recently recommended for rheumatism. He applied compresses dipped in the liquid, renewed them several times in the course of the evening, and was getting ready for bed, when he was suddenly attacked by a feeling of general distress, violent itching, and roaring in the ears, then began to swell up, and finally lost consciousness. His family thought he was dying. A colleague who was hastily summoned found him enormously distended all over (as if by inflation of air) and profoundly comatose. A large dose of salicylic acid had been taken through the skin. Under the vigorous administration of stimulants and purgatives the patient revived; the swelling subsided, and in a few days he was able to be about. Salicylic acid ointment may also give rise to serious symptoms, as I have had the opportunity of observing in several cases. A single application is sometimes followed by such a degree of swelling and inflammation that the remedy has to be discontinued. These facts should operate as a warning to pharmacists, never to dispense salicylic acid except on a doctor's prescription."

# TRANSLATIONS.*

## CARCINOMA AND ENDOTHELIOMA OF THE OVARY.

Dr. Vitalis Müller studied microscopically six ovarian tumors under the direct instructions of von Recklinghausen. The tumors appeared to belong to the above mentioned varieties.

Two primary carcinomas seemed to have originated in the Graafian follicles. One of secondary origin, whose primary seat had been in the uterus, appeared to have followed the lymph channels along the periphery of the ovarian peritoneal covering. These conditions can be explained only by accepting the theory of von Recklinghausen on "retrograde embolie." In a case of primary carcinoma of the supra-renal capsule, the epithelium of the ovarian stroma was found intimately connected with tubules lined with endothelium, and there seemed no reason to doubt that a secondary attack would have located itself in the ovary. Another tumor, belonging no doubt to the proliferating glandular variety, presented in the cyst wall epithelial layers anastomosing with each other and the lymph channels, producing the characteristic nodule. In the last case which belonged to the endothelial variety, the initial points being located in the wall of a glandular cystoma —it had originally been a multilocular cyst about the size of a child's head—the inner surface was lined by a cylindrical epithelium with an ovoid nucleus. In the wall hollow spaces could be seen lined also with the cylindrical epithelium. Close to these glandular hollow spaces, a united tubular system existed, which was lined with cubical epithelial cells. At various spots these hollow spaces were surrounded by hyaline tissue degenerating into epithelial elements; in others papillomatous degeneration could be seen.

Careful examination of the last four cases led to the following conclusions.

1. If epithelial cells have entered into and multiply along the blood and lymph channels, a histological picture presents itself, which, in many cases, cannot be distinguished from an endothelioma of the ovary.

2. Intra-canalicular papillomatous formation following the course of the lumen of blood vessels, has not been heretofore observed in undisputed cases of cancer. No differential diagnosis can therefore be made in doubtful cases, unless a careful study under the microscope has preceded it.—*Arch. f. Gynaekol. bd II.*

—W.

## OPERATIVE TREATMENT FOR TUBERCULAR PERITONITIS IN CHILDREN.

The author (L. Conitzer), reports seven cases, four belonging to the exudative and three to the dry form. All were operated upon at the Jewish Hospital in Hamburg. The histories and results are given in detail, and the author presents the following conclusions:

1. Tubercular peritonitis can be cured spontaneously in the dry form comparatively less frequently than in the exudative type, which is cured in most cases.

2. The spontaneous cures of the exudative form of tubercular peritonitis, have heretofore been regarded as cases of chronic exudative peritonitis or ascites.

3. All forms of tubercular peritonitis can be cured or at least improved by abdominal section, even though other therapeutic measures, including puncture, have been tried previously.

4. The result of the operation depends upon the form of the disease, (the best results being attained in the chronic variety), the previous duration of the disease and the eventual complications.

5. The operation is indicated when the internal therapeutics have proved of no avail.

6. The operation is contra-indicated in those patients of poor vitality, or in cases suffering from tuberculosis of other organs.

7. The question of how the cure is effected by abdominal section in these cases, has remained unanswered.—*Deutch. Med. Woch.*

—W.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

## ANATOMICAL CONSTRUCTION OF SOME OF THE GRANULAR SWELLINGS OF THE INTEGUMENT.

L. Philippson, (*Central. f. Allgem. Path. u. Path. Anat.* IV., 1893), has directed his studies to the modus operandi of infection, whether internal or external. His observations embraced chiefly syphilis, leprosy and tuberculosis. His studies resolved themselves into the following conclusions:

I. *Infection Externally.* First, syphilitic sclerosis; second, the superficial lepra nodes (?) found in the papillary layer surrounded by healthy tissue; third, superficial lupus nodes. These are all new growths, situated superficially, having sharp lines of demarcation, more or less round or concentric in form; the deeper structures are attacked later in the course of the disease.

II. *Infection Arising through the Circulation.* First, roseola, syphilitic papules; second, acute erythematous spots or papules of lepra; third, efflorescence in miliary tuberculosis(?). These new growths at the onset extend in their development throughout all the layers of the cutis and follow along the ramifications of the blood-vessels.

III. *Infection through the Lymph Channels* First, superficial nodes of leprosy developed above the cutis (?); second, miliary lupus originating from deep-seated infections.

The new growths of the third group, which may also belong to the syphilitic or leprous type, cannot be distinguished by any regular appearance, and are rather flexiform in character.—*Schmidt's Jahr.* —W.

### Prophylaxus of Puerperal Diseases.

R. Frommel (*Deutsch. Med. Woch.*, No. 10, 1892), says that from April 1, 1887, to November 15, 1890, of 559 women confined, one died of puerperal fever.

Disinfection of the genitalia, after liberal use of soap and water, was effected by a solution of bichloride 1: 2000; the cervical canal also being carefully cleansed with the same.

From November 15, 1890, to December 11, 1891, there were 197 obstetric cases, in whom the external disinfection alone was used. Of these, 3 died of puerperal fever, and the percentage of those who were ill ran as high as 11.1. As a result of these observations, the author desires to emphasize the importance of external and internal antisepsis, as also that of personal cleanliness.—*Schmidt's Jahr.* —W.

### Spelling Made Hideous.

The *Medical Press and Circular* prints the following Philistine editorial: "Many of the American medical journals are now becoming so hideous in the matter of spelling that it is a difficult matter even for an ordinary educated English medical man to read them without wishing to throw up his task in disgust. The van of this insane effort to appear novel is led by the Philadelphia *Medical News*, and now we learn that the editor of that journal is bringing out a new edition of a 'Medical Dictionary of Terms,' in which all this ne-fangled and absurd method of spelling will be incorporated. The rising generation of young American medicos are to be pitied if they are required to adopt the teaching in orthography which will obtain in this 'Dictionary.' We are glad to see that some of our leading contemporaries in the United States have not been led into disfiguring their columns by such words as 'chemic,' 'bromid,' and 'physiologic,' together with others equally absurd and hideous. The introducer of this *fin de siecle* method of spelling affirms that no argument can be advanced against it. But what about the rules of grammar and prosody so far as the English language is concerned. Perhaps under the circumstances it would be best at once to bring out a book dealing with the subject of 'The American Language: its Grammar and Orthography,' and then there would be no difficulty in showing that the American method of spelling had nothing to do with the English language."

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SATURDAY, JANUARY 6, 1894.

## EDITORIAL.

### PROSPECTIVE.

Entering upon this its forty-second year of continuous publication, the REPORTER sends greeting to the medical profession at large and to its friends and supporters, both old and new.

To its old friends but few words are necessary. You have appreciated and cordially acknowledged the REPORTER'S untiring efforts to present to you what is latest and best in the medical world, avoiding discussions of abstruse matters and giving practical information that can be made use of in your every-day work.

It is utterly impossible to bring into the pages of any one journal the complete records of current medicine, but the entire field of medical science has been carefully and thoughtfully considered by the REPORTER and only the best and most useful of all available material brought under your notice.

The change that will appear most striking to you just now, is the reduction of the subscription price from five dollars to three dollars per annum. There will be no other radical change in the journal, but a continuous, steady improvement will be made as opportunities may offer. Paid-up subscriptions for 1894 at the old rate, made before the change was announced, will cover proportionately greater time, and paid-up subscriptions at the old rate, beginning in 1893, but extending into the year 1894, will also be extended proportionately from the beginning of this year.

To our new friends it may be well to briefly state by way of introduction, that the MEDICAL AND SURGICAL REPORTER was among the very first of medical weekly journals to be established in America. Its continuous existence is sufficient evidence of its value to the medical world, and its large clientele demonstrates its influence and progressiveness. The journal has experienced the ups and downs common to journalistic existence—save that most common, failure,—and now, in its forty-second year, is in the prime of its life and influence.

It is not at all unusual, and is a most encouraging incident, for the REPORTER to receive from its older subscribers, who

have taken the journal continuously for years, congratulations on the maintained excellence of quality, independent attitude and progressive spirit displayed by it, together with the statement that the journal is better to-day than it has ever been.

You will expect to find the REPORTER a journal for the busy, every-day doctor. You will find in every issue something, at least, that will be of immediate service to you in your daily work. Its pages rarely contain lengthy technical discussions of abstruse subjects, however valuable to medical science in the abstract. There is not sufficient room, and there are other journals, more properly keeping these records. The physician in active practice, must have his facts presented to him tersely and pointedly. His munitions must be given him ready for use in the field. He has little disposition and no time for theorizing, experimenting or manufacturing. As he deals with human life, and recognizes his responsibility, he demands that his informant be trustworthy, and his information authentic. He will not risk life on the strength of hearsay, nor the assurances of advertising testimonials. The REPORTER brings him the best thoughts and experiences of the best minds in the profession, presented in a form readily apprehended and easily remembered.

As the progressive physician enlarges his knowledge and increases his success by studying the work of other men, it is his duty to his profession to allow others the benefit of his work and thought. There is no physician worthy of the name who cannot suggest something of value to others of the profession, and thus aid to advance the interests of his calling. The REPORTER desires to present such benefits to the medical world.

Again the MEDICAL AND SURGICAL REPORTER is a journal for the general practitioner. It cannot cover in detail the work done in all of the numerous specialties, but, to give as wide a view as possible, the department of *Current Literature Reviewed* was established, and here will be found in briefest form to be intelligible, the most valuable articles contained in literature devoted to specialties. This review was a new departure in medical journalism and its value was so promptly recognized that many other journals have established similar departments.

In the *Library Table* will be found notices of the most valuable recent medical books, and reviews of these works at the hands of competent and unbiased reviewers, made entirely in the interests of the readers of the REPORTER.

The reports of foreign work are taken directly from foreign journals, and translated especially for the MEDICAL AND SURGICAL REPORTER.

*Abstracts* of the most valuable articles appearing in other publications are made and their sources acknowledged.

*Formulæ* of tried value, and *Therapeutic Hints* from all proper sources, are regularly published, and the *Periscope* discovers miscellaneous items of interest and value not included in other departments.

A word with regard to our advertisers. Nothing is admitted to the advertising columns without keen scrutiny, and we are confident that our readers will find our advertisers in every way satisfactory and responsible. The policy of the REPORTER confines our advertisers to the advertising pages. Space in the reading columns is never sold, and reading notices are never given to individual advertisers. This, however, does not debar a discussion of any article which is deemed of sufficient interest to the profession, save in so far as such discussion would discriminate in favor of some individual advertiser.

The dilemma presents but two horns. All of our advertising patrons must be treated alike. Either the REPORTER must be conducted in the interests of the pro-

fession—a journal, with advertising however useful, incidental to medicine; or it must allow itself to be conducted by a variety of people, representing different interests, with medicine incidental to business.

The first has always been the policy of the REPORTER in common with all other first-class medical journals and one we do not propose to vary, as both our subscribers and our advertisers approve of it.

We commend our advertisers to the profession as desirable to deal with and as parties not needing the questionable recommendation of constant mention in the reading columns of the journal.

## ABSTRACTS.

### A NOTE ON THE NATURE AND TREATMENT OF "INFLUENZA."

Mortimer Granville in *The Medical Press and Circular* says: Whether or not the malady miscalled "Influenza" be, as I believe it is, a Chinese marsh fever, there are certain characteristics of this disease which, with the indications obviously arising from them, have been unaccountably overlooked by clinical observers and ignored by practitioners. In view of the reappearance of the malady in our midst it may be worth while to point this out and to ask a reconsideration for the whole subject of pathology and treatment.

It was in 1848 that I first made the acquaintance of influenza, and in what would now be regarded as very adverse circumstances. I was engaged in the quasi-experimental study of the so-called system of "Homœopathy," which at that time almost fascinated the intellectual portion of London Society, and was the subject of thought and talk of every *coterie*. I happened to be in the region of densest fog, and it was not until some three years later that I succeeded in reaching daylight with the discovery that Hahnemann in his "*similia similibus curantur*" had either perpetrated an elaborate travesty of wit or become the victim of an extraordinary fallacy. However this may be, I have never regretted, indeed, I am daily thankful for, the close study of symptoms, states, and the direct and indirect action of drugs, dietary, and *conditioning*—what we now call "nursing"—on the organism in disease I was thus led to pursue. In respect to influenza, three facts which then came to my knowledge are of such *practical* value that I would not for any consideration be ignorant of them; and yet, so far as I know, they are not even mentioned in any text-book of medicine or in any special treatise on this disease. Briefly they are these: 1st. The temperature—we had no clinical thermometers in those days, but estimated bodily heat tolerably correctly by the hand—is a bogus one. It is not inflammatory, and a fatal mistake would be, and, as a matter of fact *is*, made by so treating it. 2nd. There is *always*—though in a large proportion of cases overlooked, lobular, or broncho-pneumonia, that is active congestion of the lining membrane of the b onchial tubes extending to theair-cells atrthe outset of the disease. Very often the area of dulness—from engorgement—is so limited that it is not perceived, and it may change from place to place, in the same lung, or disappear in one lung and make its appearance in another in less than two hours. Important, almost pathognomonic as the existence of this broncho-pneumonia is, it does not necessarily produce any special symptom drawing attention to the fact. This is why practitioners fail to observe it, and it explains the absurd description "Influenza complicated with pneumonia." Broncho-pneumonia is the very essence of the disease, and it would be far better to call it "epidemic lobular pneumonia," and thereby avoid a world of confusion and mischievous mistake. 3rd. The treatment must be tonic throughout, and the diet especially nutritious and stimulating *ab initio*.

These were the facts learned in 1848. The explanation has come with recent years and fuller knowledge.

The high temperature is bogus, because

it is simply the results of a sudden transference of normally hot or only slightly super-heated blood from the deep vessels to those immediately under the skin and in the mucous membranes. This is the direct effects of poison on the nerve centre, the poison of epidemic broncho-pneumonia acting specifically upon the vaso-motor centre. After the rush of the blood to the *surfaces*, external and internal, there is sometimes a rapid reversal of the state of matters and the blood falls in again upon the deeper vessels, and particularly those of the liver and kidney. When this occurs the temperature falls suddenly to a subnormal point. These are not, however, the worst cases. If the effects of the poison on the vaso-motor centre are sufficiently powerful to "stagger"—almost paralyse it—the result will be asthenic dilatation of branches of arteries supplying special lobules of the lung, with result of immediate hypostatic congestion. If this last long enough in any particular region a typical pneumonia my be fully developed; but it frequently happens that the particular nerve affected recovers and the muscular fibres of this artery act again, while another branch or filament supplying some other lot shows the paralyzing effect of the poison. The poison still acts on the centre, but its influence passes from branch to branch of the vaso-motor nerve. All this time it is possible that the blood state, as distinguished from the blood-vessel state, may be natural. The mean temperatures of the blood is, as we know, 39° C., or 31.2° Reau, or 102.2 F. (a very common temperature early in influenza). So that the mere transfer of naturally hot blood to the surfaces accounts for a great part of the temperature observed. If the action of the poison on the vaso-motor centre be prolonged nutrition is disturbed and a slight rise will rapidly bring the temperature to 104. or 105°. Indeed some physiologists place the mean of the blood heat at 40°C., which would give 104F. or 32°R. at the outset.

The point to note is that the great factor in the production of the high temperature in influenza is the bringing of normal blood to the surfaces *i. e.*, within reach of the clinical thermometer, and that this phenomenon is a result of "shock" to the vaso-motor centre, and needs to be treated by stimulants not by depressants. In such a case the coal-tar derivatives, antipyrine, etc., are simply murderous agents, and I do not hesitate to affirm that cases of influenza treated by these drugs are placed in jeopardy by a blunder in art, and that the mortality of the disease has been in great part the effect of the treatment. The depressant came into action at the moment of collapse, and rendered recovery impossible.

I believe the best treatment of influenza —or as I prefer to call it epidemic broncho-pneumonia—to be by camphor and iodine combined, as follows:—

℞ Camphoræ, ..... gr. lx:
Tincture iodi, (*a*) ..... m lx;

(*a*) To avoid the depressing potass iod. so strangely introdoced in the tinct. iodi of the "Brit. Pharm."

Mucilaginis acaciæ, ..... ℥iv;
Glycerini, ..... ℥vj;
Olei menthæ piperitæ, ..... m vj;
Syrupi zingiberis, ad ..... ℥ij.

Two teaspoonfuls being given every second or third hour until recovery happens, with clearing up of the lung congestion. Meanwhile—*during the stage commonly regarded as inflammatory*, be it observed —a highly nutritious diet of meat-juice or very strong beef-tea with a sufficient allowance of champagne or brady must be insisted upon. Rarely does the malady persist more than from three to five days, and when it subsides the patient is so little exhausted that the convalescence is extremely short. The chest should be daily, sometimes twice or three times in the twenty-four hours, searched for suddenly appearing or lingering patches of congested lung, and hot stupes of turpentine or mustard poultices applied if delay occur in the recovery of the arterial tone.

I do not urge this or any other particular mode of carrying out the indications, but I maintain that these are to make a vigorous attempt to arouse and support the action of the vaso-motor centre; and to avoid anything and everything caused by any chance depression. It is not an inflammatory disease we have to combat, but a poison which threatens to kill our patients by mere collapse, and the high temperature, the congestion, and the neuralgic pains are symptoms directly arising out of, and fully explained by the inhibitory effect of the poison upon the nerve center in the manner and with the results described.

## TYPHOID FEVER AND DRINKING WATER.

We have 50,000 deaths annually from typhoid fever, and we know how to prevent these deaths. Why do we not do it? It is estimated that the life of the average adult is worth to the State $1,000. If a young man of from twenty to twenty-five years of age loses his life, it will cost $1,000 to raise another up to the same age; and I am sure that any father who is engaged in the pleasurable occupation of raising a family of boys will deny that it can be done so cheaply. But on this estimate, this Government is losing 50,000 times $1,000 or $50,000,000 annually in death from typhoid fever. This is not all that typhoid fever is costing us. For every death from this disease, at least ten other people are sick with it. Five hundred thousand people who do not die are sick each year with typhoid fever. We will suppose that the average duration of the sickness is twenty-eight days, and all phycians will agree that this estimate is too low. The person who has typhoid fever is often unable to resume his vocation within a shorter time than three months. However, we will make our estimate on the supposition that the average time lost from work by a man sick with this disease amounts to 500,000 times twenty-eight days, or 14,000,000 days which is equivalent to more than 38,356 years. Supposing that the time of the individual is worth 50 cents per day when he is well, this represents an actual loss of $7,000,000 annually, and this should be doubled, because for every person sick the time of another person who acts as a nurse is demanded. The $14,000,000 added to the $50,000,000 which is lost by death makes a total sum of $64,000,000 or about $1.00 for every inhabitant, the annual tribute levied upon this Nation by the one disease, typhoid fever. This represents approximately the amount which we pay every year for the ignorance and carelessness which we exercise in allowing this preventable disease to prevail among us.

I have said that typhoid fever is a preventable disease, and that the large number of deaths from this disease is unnecessary. This is true, not only theoretically, but practical demonstrations are not wanting. Prior to 1859 the city of Munich, in Bavaria, was a veritable hotbed of typhoid fever. There were no sewers and no public water supply. Most of the houses were furnished with large brick or wooden flues which were built from the cellar up through the different floors. Into these the excretions from the body were dropped and accumulated in the cellars. Other waste material was deposited in cesspools, and garbage was thrown into back yards. The air in the houses was foul and offensive to the sense of smell. The drinking water was taken from shallow wells in the yards, and these often received the ooze from the cesspools and vaults. In 1859 the citizens were compelled to seal tightly the bottoms and sides of these receptacles of filth, and later, a system of sewerage was introduced, and later still a supply of wholesome drinking water was obtained. Notwithstanding the fact that portions of the city still remained unsewered at the time of the last report, the results have been most gratifying. From 1852 to 1859 the typhoid deaths per 1,000 in Munich averaged 24.2. This has been gradually decreased, until in 1884 it was 1.4 per 1,000. This shows what has been done in an old and crowded city, and Vienna has practically repeated the demonstrations made by Munich. The majority of cases of typhoid fever arise from a contaminated water. That a drinking water infected with the discharges from a person sick with typhoid fever may cause an epidemic of the disease, there can no longer be any doubt. The records of sanitary science abound in histories of such cases. Every physician of large experience with this disease can detail one or more instances in which the disease has been clearly traced to infected water and I will consider that this method of the dissemination of the disease is recognized by all. It probably is a safe estimate to say that bad drinking water causes not less than 40,000 deaths each year in this country.—*Prof. Victor C. Vaugh, M. D., in the New York Independent.*

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First Tramp—"These Fifth Avenue people are very unreasonable with us."

Second Tramp—"Yes; never give money, and lecture you for being dirty."

First Tramp—"And yet, when I rang and asked for a bath only, I was refused."—*Life.*

## PROLONGED INTERMITTENT TREATMENT OF SYPHILIS.

Prof. E. Lang read a paper before the Medical College of Vienna in which he criticised the treatment of syphilis advocated by Prof. A. Fournier (Paris), who has now been induced, as the result of a long experience, gradually to increase the duration of the treatment from nine months, as recommended by him several years ago, to five or six years.

The author is of the opinion that the method devised by the distinguished French syphilographer is not in conformity with the natural evolution of syphilis. Syphilis being a curable affection at any stage of its development and even before the appearance of the secondary manifestations, it is evident that no single method of treatment will do in all cases. The therapeutical means employed must necessarily vary according to the necessities of each individual case.

In a recent publication (*The Medical Week*, 1893, Vol. I, p. 35), Prof. Fournier gives some statistics based on 1,703 cases of tertiary syphilis which, from the point of view of the duration of the treatment, may be classified as follows:

| | |
|---|---|
| No treatment | 217 cases. |
| Treated for less than one year | 1,162 " |
| " from one to two years | 265 " |
| " for more than two years, | 53 " |
| " for more than three years, | 6 " |

Prof. Fournier concludes, therefore, that out of 1,703 cases of tertiary syphilis, only 59 occurred after, and in spite of, conscientious treatment, while in the remaining 1,644 cases the accidents were due to the fact that the patients had only been very inperfectly treated, if at all.

Prof. Lang pointed out that supposing Prof. Fournier still believed that twelve months' treatment were sufficient to cure syphilis, he (Prof. Fournier) would be obliged to admit, in presence of the foregoing statistics, that tertiary manifestations occurred in 217 patients who had not been treated and in 324 (265+53+6) who had been submitted to appropriate treatment for the required period of time. The obvious conclusion would then be that, so far as the tertiary manifestations are concerned, prolonged treatment is worse than total absence of treatment.

To show that cerebral syphilis can be prevented by his method, Prof. Fournier quotes 100 cases of syphilis of the brain which can be tabulated as follows, according to the duration of the treatment:

| | |
|---|---|
| Prolonged and conscientious treatment | 5 cases. |
| Treatment of average but insufficient duration, | 6 " |
| " for from 7 to 18 months | 10 " |
| " for from 1 to 6 months | 70 " |
| No treatment | 4 " |
| Treated by iodide of potassium alone | 5 " |

This table shows, according to Prof. Fournier, that "only 5 out of 100 cases of cerebral syphilis had been submitted to conscientious treatment, while in the remaining 95 cases the treatment had been *nil* or only very imperfect or of short duration. From which it follows that cerebral syphilis is 19 times less frequent after conscientious treatment than in patients who have not been treated at all or only very imperfectly."

This statement is open to the same objection as the statistics already quoted, and Prof. Lang believes that the following conclusions may equally well be drawn from the facts brought forward by Prof. Fournier, showing how far the figures given by the eminent specialist are deceptive:

(1) Five patients out of 100 have taken nothing but iodide of potassium as against 95 who have either not been treated at all or have been submitted to some other method of treatment; from which it follows that cerebral syphilis is 19 times less frequent in patients who have been treated by iodide of potassium alone than in those who have taken mercury or nothing at all.

(2) In four cases out of 100 no treatment was applied, while in the remaining 96 mercury or iodide of potassium was administered; from which it follows that cerebral syphilis is 24 times less frequent in cases in which no treatment is employed than in those in which mercury or iodide of potassium is administered.

Indeed, Prof. Fournier himself admits that he has met with cases of recovery from syphilitic disease of the brain in which the patients had undergone a prolonged course of treatment, as well as with cases in which the patients remained free from specific manifestations of any kind, eight, twenty-four and even thirty-four years after a short period of treatment.

So far from exerting a favorable influence in cases of syphilis the method of prolonged treatment recommended by Prof. Fournier is apt, according to the author, to produce a deleterious effect on the patient's general health by giving rise to various alimentary troubles associated with insomnia and other nervous symptoms of a somewhat grave description, and favoring the occurrence of tertiary manifestations. For example, the statistics communicated by Prof. Fournier to the First International Congress of Dermatology in 1889, show that the liability to tertiary manifestations increased in his patients until the third year after infection, a fact which is in direct opposition to the experience of the advocates of the "opportunist" method who have never met with the same liability to tertiary accidents during the first three years after infection in the patients under their observation.

The statistics communicated by Prof. Fournier to the Congress were based on a series of 3,429 cases, in 1,085 of which the nervous system was the seat of syphilitic lesions, a very large proportion, even after deducting the 355 cases of tabes which are regarded by the distinguished French syphilographer as of syphilitic origin.

Lastly, Prof. Lang pointed out that Prof. Fournier has never reported a single case of reinfection in patients treated by his method, the occurrence of reinfection being a most conclusive proof that the patient had been completely cured of his first attack of syphilis. Another disadadvantage of the prolonged treatment consists in the fact that certain patients are very liable to relapses irrespectively of the method of treatment to which they are submitted; if such patients are already under the influence of mercury the administration of this remedy is not attended by the same success as it would be under other circumstances.

Dr. Finger spoke in favor of the prolonged treatment of syphilis. He maintained that so far as the liability to tertiary manifestations was concerned it was inaccurate to say that it was increased during the first few years after infection under the influence of the prolonged treatment.

Dr. Mauriac also communicated in the First International Congress of Dermatology some statistics on the same subject, from which it would appear that the tendency to tertiary accidents is greatest between the third and the sixth year, after which it gradually decreases. These facts were confirmed by the observations of Haslund and Leloir.

With reference to syphilitic diseases of the nervous system it should be borne in mind that this category comprises, according to Prof. Fournier's classification, such affections as locomotor ataxy, progressive general paralysis, the various amyotrophies, etc.; hence the large number of cases of this kind reported by this observer. As a matter of fact, Dr. Mauriac arrived at the same conclusions. It must be admitted that the prolonged internal administration of mercury is apt to give rise to various troubles, which can, however, be avoided by exhibiting the remedy in the form of external applications. Moreover, reinfection is not a conclusive proof that the individual had completely recovered from his first attack of syphilis, for there are a few cases on record of patients who had been reinfected while suffering from typical tertiary manifestations. The principal argument in favor of the prolonged treatment is the necessity of preventing the occurrence of tertiary accidents. It is generally recognized that the milder the secondary the greater the liability to tertiary manifestations; this is due to the fact that the treatment is seldom continued for any length of time when the disease assumes a mild type to begin with. Consequently some of the virus remains in the organism where it sets up various pathological processes at a subsequent date in the absence of appropriate treatment.

It is more rational, therefore, to combat the effects of the virus without interruption. The tissues being the seat of infective processes for three years after inoculation, the patient should be more or less under treatment during the same period of time. To prevent mercury from accumulating in the system, the administration should be suspended at intervals to permit of the elimination of the remedy. In concluding, the author said that he had employed the method of prolonged treatment for the last ten years with very satisfactory results.—*Medical Week.*

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Cleanliness is next to godliness; but small boys should not go swimming on Sunday.

## ON THE CARE OF INFANTS AND YOUNG CHILDREN ACCORDING TO THE BIBLE AND TALMUD.

The following is an indication of the subject-matter of Dr. Finlayson's article in the *Medical Magazine*, October, 1893:—

The Talmud gives direction to the pregnant and the nursing woman as to the management of her health, particularly in the matter of diet, and it indicates the evils that may be expected to result from a violation of these rules.

The fœtus was believed to originate from three sources—the father, the mother and the Lord. To the first it owed the white portions, whence were derived the bones, nerves, whites of eyes, etc. The second contributed the red portions, from which were developed the skin, flesh, colored part of the eyes, etc. God gave the spirit, the intellectual faculties, and the power of movement.

The Talmud teaches that an angel takes charge of the embryo from its very beginning, and educates the fœtus "in all sciences, but especially in the study of the Mosaic and Rabbincal laws. At the moment when parturition begins however, the angel gives it a slap on the mouth, and all it has learned is forgotten."

An explanation is given of the origin of sex. If the male seed gets first into the womb at coitus, a female child is the result, and *vice versa*. Indications, too are furnished for the detemination of the sex before birth. Thus, "a woman who is pregnant with a male child ought to have a better complexion, and the quickening should occur earlier, and parturtion also ought to be easier and less painful. The last mentioned circumstance is especially insisted upon by the Talmudists."

Hermaphrodites were excluded from civil and religious rights, but operations were performed to remedy some malformations such as imperforate anus and hypospadias. Allusion is here made to the tradition that Moses and Job had congenital abscence of the prepuce.

The desire for male issue was strong among the Jews, and Rabbi Elazer knew how to take advantage of it. He says, in answer to the question, "What is a man to do in order to beget male children?" "Let him disperse his money among the poor in alms."

The expression "stool," "stools," or "birthstool," which occurs in Pharaoh's order to the Hebrew midwives, has given rise to much discussion, and question cannot be regarded as settled. It is possible that "upon the stools" of the authorized version ought to be rendered "on the wheels"—*i. e.*, before the potter's vessel comes off the wheels, the idea being (and this view is supported by the midwives' reply to Pharaoh) that Pharaoh intended that the babes should appear to have been still-born and not to have been killed.

The fact of the prolonged period of separation of a woman after a female birth as compared with a male birth (as enjoined in Leviticus) is familiar to all and must appear strange to modern obstetricians. There is no doubt, however, that in the times of the Talmud, the idea was generally prevalent that a labor which resulted in the birth of a female child was more severe than that which gave birth to a male. To account for this supposed fact, a writer in the Talmud says that the female fœtus turns around before birth, so as to present with the face anteriorly, while the male presents with the face posteriorly. Curiously enough, a pseudo-Hippocratic writer describes the period of lochial purification as being from twenty-five to forty-two days for a girl, and twenty to thirty for a boy. His explanation, however differs from that of the Talmud.

The subject of circumcision naturally receives much attention from the Hebrew writers, and in the Talmud also expression is given to the popular notion that "the child born at the term of nine months, or of seven months, is regarded as viable, but it is considered not viable if born at eight months."

The Talmud further gives rules for deciding the question when a child has been actually born. It indicates the circumstances under which an operation compromising the life of the child is justifiable and ordains the breathing in of air as the means to be used to resuscitate the apparently still-born.

The after-birth was sometimes treated with oil, and wrapped in wool or cotton, as a smypathetic measure calculated to warm and revive the new born infant.

The Hebrew writers inculcate the duty that devolves upon mothers of nursing their own children, but abundant reference

is made to other nurses and it is probable that wet nurses were sometimes hired.

"In three different cases, females ought to make coition unfruitful by using a tampon in the vagina—viz., a delicate girl still immature, a pregant woman, and a woman who is suckling. The first, so that, if she chances to conceive, she may not have to atone for parturition by her life; the next so that a second fœtus may not be formed, and press to death the one already in the womb; and the last, so that her babe may not be caused to pine away by the occurence of pregnancy."

"Nursing women do not menstruate because the blood is transformed into milk.'

The weaning of children is often referred to. A very instructive allusion occurs in 2 Macc. vii, 27:—"O my son, have pity on me that bare thee nine months in my womb, and gave the suck three years, and nourished thee, and brought thee up unto this age, and endured the troubles of education."

The prophet Isaiah speaks thus of the growing child:—"Butter and honey shall he eat when he knoweth to refuse evil and choose the good."

## INTRAVENOUS INJECTION OF SALINE SOLUTION IN SEVERE HEMORRHAGE.

Dr. P. Horricks read a paper on this subject before the Obstetrical Society of London. He pointed out that injections of various fluids had been recommended for centuries in cases of severe hemorrhage, but it was Dr. Wooldridge who first advocated the use of normal saline solution in place of blood, the injection of which he said was attended with great danger and was less efficacious. Following up Dr. Wooldridge's ideas in this subject he had published his first successful case in 1891. He referred to the following theories and facts which had led up to the practice of saline transfusion:—(1) Death from hemorrhage results from failure of the heart caused by distension due to the great and sudden fall in the blood pressure; (2) In death from hemorrhage sufficient fluid remains in the blood vessels to carry on life if it could be made to circulate; (3) Theoretically, half the volume of blood could do the same work if it were given double the velocity; (4) The blood pressure could be raised if as much fluid were transfused as there had been blood lost. Dr. Wooldridge performed an experiment with two dogs as nearly as possible alike in size, etc. Both were bled to death, *i. e.*, until they had ceased to breathe and were pulseless. One was left untouched and never showed signs of life again. The other was transfused, the water used being equal in amount to the quantity of blood removed. The dog immediately jumped up and recovered without any signs of ill-effect. Since September, 1891, this method had been largely used not only in hemorrhage but in collapse without hemorrhage, though personally he had had no experience of its employment in the later condition. He would be afraid that the overfilling of the vessels might determine death from over-distension of the heart when the reaction set in. He thought, however, that no case of loss of blood should be allowed to pass without an attempt being made to revive the patient by transfusion. In all the cases referred to later the patients were pulseless, but he pointed out that even if a patient were not actually pulseless he or she might nevertheless have lost enough blood to determine death. Death in such cases was attributed to shock, etc., though in reality it was due to loss of blood. He had never seen any harm follow transfusion except a little suppuration at the wound over the vein.

*Case* 1.—E. L., æt. 29, was the subject of an extra-uterine gestation of some five weeks' standing which had ruptured, determining severe internal hemorrhage. She was immediately operated upon, but the quantity of blood effused was so great that she appeared to be moribund, breathing having ceased and the pulse at the wrist being imperceptible. The case appeared hopeless, but transfusion was persevered with until some *six pints* of saline fluid had been infused. The pulse gradually returned, and she recovered without a bad symptom, except some suppuration along the drainage tube.

*Case* 2.—The patient, æt. 33, had her last period November, 1892. She had an attack of pain in the abdomen on Febru-

ary 13th, and again on the 16th, when she became blanched. The circumstances being unsuitable for operation in the house she was brought to Guy's Hospital where she was immediately operated upon. It proved to be an ectopic gestation, and after the operation the patient was carried back to bed pulseless and hot water containing ʒj to the pint, of salt was injected until five pints had been transfused. The pulse returned. The patient made a good recovery though her temperature went up, reaching 101° on the 4th, and 103.4° on the 8th day, with vomiting and diarrhœa."

*Case* 3.—E. S., æt. 28. Had seen nothing for two months, though usually regular. A fortnight before she had been seized with acute pain in the abdomen with vomiting, and she passed blood *per vaginam*. On October 26th, on getting out of bed she fainted and became very pale. Before the operation the patient became quite pulseless, and intravenous injection was commenced as soon as the pedicle was tied. Six pints of saline solution were injected, and she made a good recovery.

*Case* 4.—A. T., æt. 36, in the seventh month of her eleventh pregnancy. had severe hemorrhage. Podalic version was done, during which the patient became pulseless and saline injection was begun when the pulse once more became perceptible at the wrist. An hour later it became imperceptible, so more saline solution was transfused, but in spite of a further improvement the patient sank and died. Post-mortem, a large effusion of blood was found in the left broad ligament with a tear in the cervix extending into the broad ligament. There was no blood in the peritoneum.

*Case* 5.—J. M., æt. 44, was admitted to Guy's Hospital with hemorrhage, due to cancerous growth of the cervix. The growth was removed by means of the galvano-cautery, but owing to its becoming too heated, copious hemorrhage followed. The patient became very collapsed and the pulse was almost imperceptible at the wrist. Just over three pints of saline solution were injected. The patient recovered in spite of the fact that both broad ligaments had been cut into, and the base of the bladder damaged.

*Case* 6.—This was another case of ruptured tubal pregnancy, and copious hemorrhage followed the partial detachment of the placental mass. Much time was also lost looking for a sponge which was erroneously declared to be missing. The patient was very prostrate, and seemed at death's door. Six pints of saline solution were injected but the patient succumbed on the fourth day from suppurative peritonitis.

*Case* 7.—This case was that of a young married woman who soon after marriage developed tubal gestation. Operative assistance was refused for the moment, but subsequently he received a telegram that the patient was being brought to the hospital. She, expired however as she was placed on the operating table. Brandy was injected subcutaneously, artificial respiration was tried, and then his assistant commenced intravenous injection, but with absolutely no result. After a few pints had been injected he opened the abdomen and removed the specimen of ruptured tubal gestation, which he showed. This case, he pointed out, showed the danger of delay, and also demonstrated the fact that the heart and vessels did not long retain their power of carrying on the circulation if once stopped. He suggested that the proceedure offered a better chance of success when the bleeding vessels could be secured before transfusion was begun.

Dr. Herbert Spencer reproached the author with not having referred to his (Dr. Spencer's) observations on this point, his case, published in April, 1888, being the first in which the transfusion of normal saline solution was resorted to. He agreed that a trial ought to be made of this method in every case in which death from hemorrhage was threatened, but he urged that there should be greater accuracy in the proportion of salt used. He asked what physiological authority the author relied upon to prove his assertion that pure water might be used with impunity. By using a jug instead of a funnel the necessity for skilled assistance was dispensed with. The injection of very hot or very cold water might be followed by syncope, and some danger also attended too hasty an injection. In some cases, where the jug had been held too high, he had noticed recurrent pulsation in the veins, pointing to over-distension of the heart. He did not think that six pints was the outside limit of the injection, and in case of necessity he would not hesitate to employ more.—*The Medical Press.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE ANNALS OF GYNECOLOGY AND PÆDIATRY

for December. Dr. Frank W. Talley contributes a paper on

**Irrigation of the Non-puerperal Uterus.**

The instrument used by the author for the operation consists of a small canula, slightly bent at its uterine end to facilitate introduction, perforated at the end and sides, allowing the escape of the irrigating fluid in every direction, and provided with two pieces of wire soldered to its side, so that a space may be preserved between the canula and uterine wall, permitting the return flow of the fluid, and providing for the washing of the mucous membrane of the uterine canal throughout its course. The instrument has been made of such size as will just pass through a No. 15 French catheter scale. For convenience in office practice the author uses a speculum having the lower valve guttered and provided with a funnel on its distal end to which a rubber tube may be attached leading into a slop-jar placed at the foot of the table. The fluid used in the irrigation consists of a solution of one drachm of bicarbonate of soda, and thirty grains of carbolic acid to the quart of water at 110° F. From two to four quarts of such solution are used. The author advises that the cervix be mopped with a solution of carbolic acid 1:40 in order that no septic matter be carried into the uterus. The conditions which the author believes particularly applicable to the treatment are endometritis, metritis and subinvolution. He states that there is no danger of uterine colic if all the solution is allowed to drain away, and the uterus permitted to empty itself before the canula is withdrawn.

**Pelvic Congestion**

is discussed by Dr. Almon Clarke. The author believes that pelvic congestion is accountable in a great measure for the persistent nausea of pregnancy. Post partum hemorrhage he also attributes to the same cause and instead of the use of ergot recommends morphia and the tampon. Afterpains he also regards as the result of engorgement of the uterine vessels. The cause of the congestion he thinks in the majority of instances is constipation and the accumulation of feces in the large intestine and wherever pelvic congestion exists fecal accumulation should be looked for. If not found the case should be treated as if it were a known fact, and the treatment will often prove its existence. The treatment therefore should be directed to the relief of the accumulation of feces and should consist in clearing the whole length of the colon and keeping it clear, and afterwards promoting absorption and strengthening the weakened blood vessels by massage, electricity and such other local and general treatment as may be indicated.

Dr. Charles P. Noble presents the

**Report of Two Years' Work in Abdominal Surgery at the Kensington Hospital for Women, Philadelphia.**

Ninety-nine celiotomies have been performed with five deaths, none of which were due to infection on the part of the operator. The importance of early operation in pelvic troubles is urged by the author. In regard to the matter of the use of drainage, the author says that the only evil which he can attribute to drainage in his hands is that it prevents a perfect apposition of the abdominal wound and, therefore, he believes it is a predisposition to hernia. He drains all septic cases and all cases which he believes to be septic and all cases in which he expects much leakage after the operation. Gauze drainage he thinks is of value in certain cases. In incomplete operations and when there are extensive raw and vascular surfaces, he thinks it a most useful addition to the surgeon's armamentarium, but these conditions are seldom met with. It is to be used wherever the surgeon wishes to favor the formation of adhesions, which fact shows that its usefulness is limited, because, as a rule, adhesions are not to be desired. The author advocates the Edebohls method of suturing the abdominal wound by means of a row of buried sutures. Appended to the paper is a table of the operations performed.

Dr. Joseph Price presents the "Report of a Group of Interesting Cases of Abdominal Surgery." He reports the removal of an ovarian tumor from a lady aged 75 years. He dwells especially on the advantages of drainage in proper cases, the dangers and disadvantages of the use of opium in any form and the necessity of a previous surgical training in those who would undertake abominal surgery.

Dr. M. A. Poncet contributes an account of the final illness and death of Dr. Emil Blanc from a very acute septicemia of puerperal origin, through infection of the finger. The infection was received during the removal of the debris of the placenta from one of his patients, who was suffering from puerperal inflammation.

Dr. Thadeus A. Reamy reports the "Removal of Fibro-myomata with the Pregnant Uterus, Eleven Weeks Gestation, by Baer's Method. Recovery."

In the Department of Pædiatry is the report of a clinical lecture by Dr. H. Augustus Wilson on "The Mechanics of the Human Foot and Cases Illustrating Lost Mechanical Functions and their Restoration."

THE PACIFIC MEDICAL JOURNAL

for December. Dr. Harry M. Sherman describes a

**Splint Opener for Plaster-of-Paris Splints**

and other simple devices. In the saw for cutting the splint the back of the saw blade

is ground down to a knife edge for about an inch back from the point. Ten teeth to the inch have been found to make the best saw. The handle is put on a higher level than the blade by means of two elbows. The opener consists of two blades and handles joined so that when the blades handles are approximated, the blades are separated. The blades, when in contact, will just fit in the cut made by the saw and are held from slipping on the plaster by little serrations.

As regards the most convenient places for sawing the splints: on the upper arm the cut should be along the external surface, and if the splint is a spica of the arm and trunk, a second cut must be made through the trunk portion under the arm of the opposite side; on the arm and forearm the cut should be along the posterior aspect of the arm, over the tip of the elbow, and along the ulnar border of the forearm; on the forearm and hand it should be along the radial border of the forearm and hand and thumb, and the outer side of the forefinger.

In splints of the lower extremity, a spica of thigh and pelvis should be cut down the inner aspect of the thigh, and the pelvic portion over the ilium of the opposite side; on the thigh and leg the splint should be cut down its outer aspect; all splints that take in the foot should be cut down their posterior aspect and then along the sole of the foot.

The author also describes an aluminium chin collar and fork for use in supporting the head in cases of disease of the cervical vertebræ, and a night shoe for cases of talipes.

In the treatment of hip-joint disease by traction in bed, or in the treatment of cases after resection of the hip, or in any case where there is a tendency to rotation outwards or inwards at the hip, the foot-holder described in the paper is useful. It is merely a sole of wood fastened by its heel at right angles, to the middle of a slat of wood about ten inches long. The sole is strapped to the foot by webbing, somewhat as the old-fashioned skates were strapped on, and the slat lying on the bed prevents any rotation of the limb. A peg projecting from the toe of the wooden sole is to hold the bed clothes up from the foot.

The fastening of webbing and plaster and buckles *et id omne genus*, is a tedious process by needle and thread, and the eyelets ordinarily used weaken the material by cutting threads. The simplest way is by steel wire staples fastened by the hand-staple press, such as can be bought at any large stationer's tore, and are intended for fastening manucripts and pamphlets. These are easily adusted, hold firmly as long as they are needed and then are removed with little difficulty.

Dr. S. R. Mather reports "A Fatal Mistake" made by a French surgeon where the small intestine was found firmly sewed up in the wound made during an abdominal section. Symptoms of strangulation ensued soon after the operation but the surgeon had gone from the city and did not return in reponse to a telegram still the patient was moribund. She died duriug an operation for relief of the strangulation.

Dr. W. F. Southard concludes his paper on "The Modern Eye" and Dr. Gustav Dresel discusses the subject of "Ophthalmoplegia," reporting an interesting case.

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THE NEW YORK JOURNAL GYNECOLOGY AND OBSTETRICS,

for December. Dr. William M. Polk contributes a paper on

**Hysterectomy (Supra-public) for Salpingitis and Ovaritis.**

He does not accept the proposal in whole, because by so doing, all idea of conservative surgery in dealing with the appendages is necessarily abandoned. He believes however that the uterus which is deprived of its appendages is not only useless to the individual but is a source of positive evil, and that the dangers of the operation are insufficient to forbid its application in the usual case of salpingitis. He says to those who repudiate conservative operations upon the appendages that complete work demands the removal of the uterus along with the appendages; and to those who accept conservative operations upon the appendages that when these organs are sacrificed the principles of conservatism to not apply to the uterus which should then be removed. He is of the opinion that the Trendelenberg position is a necessity in performing the operation and advocates the complete operation by means of ligatures instead of the nœud.

Dr. Marcus Rosenwasser discusses

**The Uterine Sound Its Use and Abuse.**

He describes the intrument, its indications and use as well as the counterindications and abuse. He lays down the following laws in regard to the instrument:

1. Let none use the sound who have not the necessary experience in bimanual palpation to make an approximate diagnosis in pelvic disease.
2. Strict asepsis of hands, instrument and field of examination are enjoined.
3. A thorough familiarity with the technique is essential.
4. Use the sound only for necessary information concerning the inside of the uterus not otherwise obtainable; or to induce early abortion; or to assist in replacing a movable uterus in exceptional cases.
5. Don't use the sound when irritation or inflammation already present would be increased; or when it would be the carrier of disease products or germs; or when its use would be likely to cause injury to agglutinated organs; or lastly, when the information gained would be inessential.

Dr. T. J. McGillicudy reports two cases of "Acute Puerperal Inversion of the uterus." One case died twenty-four hours after the accident, the other recovered. He is of the opinion that many cases of partial inversion or indentation at the fundus occur which rectify themselves, but which under favoring circumstances would have become cases of complete inversion.

The remaining papers in this issue are: "Subinvolution of the Uterus, and its Treatment by Electricity," by Dr. Charles G. Cannady; and a sketch of the life of Dr. Charles Jewett.

# PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

## THERAPEUTICS.

### Chloroform as a Hæmostatic.

As a general hæmostatic for controlling of external bleedings, arterial, venous, or capillary, chloroform is most valuable. Applied on a dossil of lint or cotton wool to the bleeding surface, it promptly stays the blood, acts as a direct stimulant to the patient, and leaves no blood crust to fall off and recommence the bleeding. It is peculiarly suitable for all abdominal operations, as it has no tendency to excite inflammation either in the part to which it is applied or to any of the surrounding tissues.

As an antiseptic application it is more powerful than bichloride of mercury solution The addition of gum resins has been suggested, but they would detract from the value of the application instead of increasing it, for the reason which will occur to any person familiar with the use of solutions of gum resins.—*Medical Press.*

## MEDICINE.

### Congenital Absence of Right Kidney and Suprarenal Capsule.

The following case may be worthy recording: A man, aged fifty-one, was admitted into the asylum suffering from melancholia. He was a fairly well developed man but rather poorly nourished. The skin of his face and body was of a dusky brown color, the pigmentation being deeper in the regions of the axillæ, penis and scrotum. The heart's action was weak, and he had a small, feeble pulse. He complained of a feeling of nausea and frequent vomiting and retching. A tentative diagnosis of probable Addison's disease was made, and he was placed under special observation. The patient committed suicide by strangulation on August 17th. At the *post-mortem* examination the ordinary signs of strangulation were found; but the point of interest was that there was an entire absence of the right kidney and suprarenal capsule. On dissection, no trace of the missing organ could be found, nor was there any vestige of a renal or suprarenal branch of the aorta or vena cava on that side. The right ureter also was entirely absent, and on opening the bladder only the left ureteral apeture could be found. The left kidney was quile healthy but of large size, weighing 9½ oz.—Ernest W. James, M. R. C. S., in *British Medical Jour.*

### Some Observations respecting the Pathology and Pathological Anatomy of Nodular Cystitis.

Dr. Samuel Alexander, states that in certain cases of prolonged cystitis there have been observed, in addition to the usual changes due to chronic inflammation, a number of small nodules in the mucus membrane of the bladder resembling the enlarged solitary lymph-follicles of the intestine. These nodules in the bladder vary in size from a small pin-head elevation to that of a large pea. Their number and situation likewise vary in different cases. Simular nodules have been observed in the posterior urethra, in the ureters, and in the renal pelves, but the study of these lymphoid formations in the urinary tract has excited very little interest, and it is still an open question whether the nodules observed in inflammatory conditions represent a normal part of the mucous membrane of the urinary tract, or to be regarded as new pathological formations. After a long and painstaking investigation, Professor Alexander has arrived at the following conclusions in regard to this condition:

1. That the lymphoid nodules which occur in certain cystites represent a part of the normal mucous membrane of the bladder, and that the same is true in regard to nodular inflammations of the renal pelves, the ureters, and the posterior urethra.

2. That when there are a great number of lymphoid foci in the normal mucous membrane, infection of the bladder, if prolonged, is likely to assume a peculiar type, due to the enlargement of these foci into prominent and very vascular nodules, and that these cystites should be regarded as a special clinical variety, to which the name nodular cystitis should be given.

3. That in cases of tubercular infection of the bladder, in which there are numerous lymphoid foci present in the normal bladder, these become enlarged, and as a result of the special infection undergo degenerative changes which are characteristic of tuberculosis.

4. That the lymphoid foci in the normal mucous membrane vary greatly in size and number, that prominent lymphoids nodules may occur in a bladder apparently normal, and without previous inflammation. This, however, is very exceptional, and it cannot be positively asserted whether the enlargement of the nodules in these cases is a normal or pathological condition.—*Jour. of Cutan. and Genito-Urinary Dis.*

### Post-Mortem Idrosis.

A writer in the *International Medical Magazine* records the following curious phenomenon in a case of death from angina pectoris. "The face of the corps seemed to be bathed in perspiration, the moisture reproducing itself after being wiped off, in spite of the presence of rigor mortis and other unmistakable evidences of death. This most extraordinary phenomenon was witnessed by several local physicians who also viewed the body. The funeral was on that account delayed several hours until decomposition had fully set in."

### The Chemistry of Fatigue.

According to Lagrange, the general effects following fatigue are due in part to the chemical changes which take place in the muscles as the result of physical exertion, and in part to the changes induced in the various organs in consequence of their increased functional activity of which exertion is the cause. The chemicial changes which are produced in a muscle in activity consists in the formation of diverse abnormal chemical products, the residue, in fact, of excessive combustion, which always accompanies muscular contraction. There is present in a muscle, which is over fatigued, lactic acid, creatinine, uric acid, and these products gradually find their way into the blood, and so become generally disseminated. In the course of some hours they are eliminated by the urine as chemical analysis shows. While, however, these abnormal products are circulating in the blood they cause symptoms of a more or less toxic nature, such as a feeling of malaise, general lassitude, prostration, and sometimes even a rise of temperature.—*Med. Press and Circular.*

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### Functional Diseases of the Alimentary Canal Accompanying Climatic or Temperature Changes—Etiology, Pathology and Clinical History.

Dr. F. W. Shaw in concluding his paper offers the following conclusions:

First as to etiology:

1. Any cause at any time of the year which creates in the intestines a condition of catarrh.
2. Fatigue or sudden chilling of the body.
3. High temperature and humidity.
4. Micro-organisms contained in air, water or food.
5. Any intestinal irritation or absorption of poisonous ptomaines.
6. Infection externally from decomposition of stools.
7. Active specific bacilli.
8. Age and individual powers of resistance.

Pathology:

1. Simple congestion of intestinal mucous surfaces.
2. Inflammation of stomach and intestinal mucous surfaces with loss of epithelium, and in severe cases loss of mucous and submucous tissue with intestinal infiltration.
3. Ulceration with loss of substance.
4. Infiltration of solitary and mesenteric glands.
5. Formation of membranous coatings to intestine.
6. Grave constitutional symptoms with no marked pathological intestinal changes.

Clinical history:

1. Simple gastric or intestinal dyspepsia with nausea and vomiting with no constitutional symptoms.
2. Enteritis, gastro-enteritis, entero colitis and colitis with marked local and grave constitutional symptoms, approaching in the latter case those of collapse.
3. Sudden death within a few hours of attack, with no intestinal signs of pathological changes.
4. Diarrhœas in all degrees of intensity, frequency, color, consistency and composition.
5. Vomiting, consisting either of mucous, undigested food or other stomach or intestinal materials, bile, blood or serum mixed with intestinal contents.
6. Specific action of certain pathological germs upon starches and sugars, resulting in an acid fermentation, and lastly, a similar action of other germs upon albuminoids, resulting in an alkaline fermentation.—*Brooklyn Med. Journal.*

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### The Condition of the Urine in Relation to Anæthesia.

Porter, of New York, writes in the July number of the *Post-Graduate* quite a long paper upon the subject, and concludes:

1. That either and chloroform act upon the same principles, but with results developed by slightly different methods.
2. That both are capable of producing death at the time of the anæsthesia; cholorform more frequently than ether.
3. That ether causes as many, if not more, deaths than chloroform, but the fatal issue is delayed until the patient has recovered from the operating-table.
4. That by a careful study of the density of the urine and its causes we are in possession of exact information by which we can determine the nutritive condition of the system and are forewarned as to the possible outcome of the anæsthesia. It also enables us to judge which anæsthetic is best adapted to the individual case in question.
5. We are taught that neither ether nor chlorosorm should be administered until the glandular organs, in their necessarily damaged state, are put in the best possible condition to endure this extra strain. When this is a general rule many cases that now prove fatal will be saved.
6. It teaches that every public institution should have paid a physician who is competent to examine the urine and determine through it the status of the physiological economy before giving the anæsthetic. It should also be the duty of this same physician to administer the anæsthetic, for he alone knows best which anæsthetic to select with a given condition of the system, and is also better able to guide the patient safely through the anæsthesia than one who knows nothing of the constitution of the patient except from a second part.
7. While it is clear that death in some instances is directly due to the primary effects of the ether and chloroform, and in others to the secondary effects, it should not deter us from using them, but stimulate us to be more throughly master of their actions upon the system and to guard against their ill effects. When all this is accomplished, chloroform will probably hold the first place as an anæsthetic.

**Hernia of the Appendix—A Report of Forty-one Cases.**

Dr. Briege, of Breslau, has collected a series of 41 cases, 20 inguinal, 15 femoral, and 16 variety not stated. In 26 cases operation was performed; 16 cases were entirely cured, two were cured, but had a fistulous opening remaining, five died, and in three the result is not stated. From a study of these cases, Dr. Briege comes to the following conclusions:

(1) Hernia of appendix vermiformis is more frequent than is generally accepted.

(2) It is impossible to diagnose with certainty a hernia of the appendix. Where there are present the symptoms of an incarcerated hernia in the right inguinal or femoral region, one should think of the possibility also of a hernia of the appendix.

(3) A hernia of the appendix may produce more or less severe complications, inasmuch as the appendix is so frequently the seat of pathological process.

(4) This form of hernia demands early operative interference, because of the threatened complications which may arise from the appendix.

(5) This operation must, almost without exception, consist of resection of the appendix. The appendix must not be returned unless absolutely normal.—*Archiv. fur Klin. Chir., Ann. Surg.*

**Variola, Varioloid, and Varicella.**

Biedert agrees with the conclusions of McCollom (*Boston Med. and Surg. Journ.*):

1. That varicella is often accompanied by considerable disturbance of the general economy.

2. That varicella is not necessarily a disease of childhood only, at least not of very early childhood. To which conclusions Biedert would add:

3. Varicella is sometimes to be distinguished only with difficulty from mild cases of varioloid or modified small pox in those who have been vaccinated. Under some circumstances it cannot be distinguished with certainty.

4. This has reference to the diagnosis only, and of course not to the real identity of the diseases.

Of variola he draws the following conclusions:

1. Up to the stage of eruption, variola is either not contagious or less so than later. Light varioloid is much less so than severe or very severe variola.

2. Many unvaccinated individuals show a lessened susceptibility; by others the susceptibility is so great that even one or two years after vaccination they are liable to the disease.

3. In the majority of individuals vaccination protects for seven years; in a larger or smaller number considerably longer.

4. Protection begins about eight days after successful vaccination. Vaccination after infection has already taken place does not protect; yet it is possible that the course of the disease is favorably modified, if the vaccination has been done at least seven days before the eruption.

5. Vaccination laws are insufficient in so far as they permit many children to remain for a long time unvaccinated, and thereby become possible sources of an epidemic, as was the case in the present epidemic.

6. The more persons unprotected by vaccination and by revaccination, the greater is the danger in a community of an outbreak and of the spreading of an epidemic.

7. Isolation and disinfection are the more unsuccessful, in combating the disease, the more unvaccinated and improperly vaccinated persons there are in a neighborhood. An immediate vaccination of all such is necessary.

8. Energetic ventilation and the exposure of persons who come in contact with the patients to fresh air diminish the danger of contagion. Steam disinfection of the effects removes the danger from that source. Disinfection by sulphur alone may be sufficient.

9. In regard to treatment, these studies add nothing to what is already known.—*Archives of Pediatrics*, 1893 *Jahr. f. Kinderk. Leipzig*, 1892.

## SURGERY.

**The Value of Stretching the Sphincter Ani in Chloroform Collapse.**

In the long sad lists of deaths, says Dr. Alexander Duke (*Lancet*, London,) from chloroform in which the various means adopted for resuscitation (unfortunately ineffectual) are enumerated, I observe no mention of one of the most valuable, in my opinion, viz., *dilatation of the sphincter ani.*

This proceeding has been, I understand, in use in America for some time past, and is highly spoken of by Dr. Daily, in the *New York Medical Times*, Feburary, 1893, as effective in cases of morphine poisoning.

I had lately an opportunity of putting to the test this plan of treatment in the case of a patient almost moribund after chloroform administration. The usual means having failed to obtain any response, I introduced my thumb into anus, and forcibly drew the sphincter towards coccyx. This had the immediate effect of rousing the patient sufficiently to gasp and cry out, and when repeated later on (as she showed signs of relapsing into the former condition), she so far recovered as to protest in a marked way against its repetition.

Dr Daily's plan is to use a bivalve rectal speculum, and by its expansion to stretch the sphincter. As the speculum may not be always at hand, I think the finger (or thumb being stronger) will be found to effect the desired result.

Of course one case does not prove much, but by observation of its immediate effect in stimulating the respiratory functions, as stated in this paper, lead me to think it a most valuable and harmless proceeding.

The sphincter ani being the last portion of the body to give up its sensibility, the converse must be equally true, hence the importance, to my mind, of adopting this plan when the patient after an anæsthetic shows signs of collapse.

I trust that trial will be made of this American doctor's valuable suggestion, as I am convinced its importance is not known, and may be the means of saving life when the usual treatment has failed.

### Resections of the Kidney.

Kummel (*Arch. fur Klin. Chir.*) publishes an interesting article on the subject of "Resections of the Kidney," in which, after referring to some experimental reasearches with regard to resections of the kidney in animals, he describes his own experience of three such operations in human subjects—noting similar operations already performed by Czerny in 1889, and by Waitz in the same year.

Of the writer's three patients, the first was a woman, aged forty-one, from whose right kidney he removed a stone of the size of a walnut. Finding a portion of the kidney practically destroyed by multiple abscesses, he removed that part of the organ. The wound made in the kidneys was only partially sutured—that part of it left open was sewed to the skin—and packed with iodoform gauze. The wounds healed completely, though slowly, and the patient made an excellent recovery.

The second case was a male, aged fifty-four. The chief symptom was pain and tenderness in the region of the right kidney, and hæmaturia. An incision was made parallel with the costal arch. On exposing the kidney there was seen at its upper end a yellowish area about the size of a walnut. This, together with a wedge-shaped section of the kidney, was excised. Sutures failed to control the hemorrhage. The kidney wound was thereupon fixed to the outer wound, and packed with gauze. The wound healed rapidly. The patient left the hospital at the end of three weeks, apparently well. Six weeks later he returned. A tumor of the bladder was then discovered. This was excised through a supra-pubic cystotomy. Rapid healing and recovery followed. The wound made in the bladder by the excision was sutured. Ten weeks after the last operation the patient died of pneumonia and empyema.

The third case was one of echinococcus of the kidney, in a woman of thirty-four. In this case the kidney was reached by a similar incision to that practiced in the two preceding cases. The kidney was greatly enlarged. Numerous echinococcus cysts were found, and freely incised. The cysts were then excised, together with portions of the kidney adjacent, by wedge-shaped incisions. The sutures failed to control the hemorrhage, as in the second case; and the kidney was, as in that instance, fixed to the outer wound and packed with iodoform gauze. About one-half the kidney was removed, the pelvis not being injured. This patient made a good recovery.—*Bost. Med. and Surg. Jour.*

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Milton reports the "Extraction by Laparotomy from the Human Bladder of the Largest Stone ever recorded as successfuly removed."

This stone weighed thirty-four and one-half ounces. The patient was an Egyptian, aged sixty. A mass extending to the umbilicus could be felt, and a sound passed into the bladder came at once upon a stone. An abdominal incision was carried from the umbilicus to the pubes, exposing the anterior surface of the bladder. An attempt was made to strip the peritoneum from the ant terior face of the bladder; but it failed. Thereupon the peritoneum was incised freely. The bladder was next incised, from its summit to its neck anteriorly—its peritoneal covering being, of course, divided. After making two lateral wounds in the course of the first bladder incision, the stone could be delivered by upward pressure exerted by two fingers in the rectum. The bladder wound was closed, except for a small opening at its lower part, with silkworm-gut sutures; the peritoneum with catgut, and the outer wound, except at its lower angle, with silver wire. There was no peritoneal reaction afterward; and the patient recovered from the operation, but died about two months later. The autopsy showed advanced disease of both kidneys. The largest diameter of the stone was six inches.

This case is especially interesting in view of the recent advocacy from various quarters, of opening the bladder through its serous surface as well as below, in order to get more room to work in, in certain difficult cases. —*London Lancet.*

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Dittel has recently reported a case of total extirpation of the prostate, with recovery, in a man of thirty-two, who had been suffering from severe hæmaturia. A suprapubic cystotomy showed the source of the bleeding to be from a tumor (afterwards shown to be a fibroma) springing from the prostate. The growth was thought to be too large to allow of satisfactory removal through the suprapubic wound, and it was reached from below by an incision from the coccyx to the anus, separating the rectum from its attachments and then exposing the prostrate by an oval incision. The urethra and bladder were not opened in this operation. Through this opening the prostate was wholly removed. The bladder was drained through the urethra, and the wound packed with iodoform gauze. The patient made a perfectly satisfactory recovery.—*Bost. Med. and Surg. Jour.*

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## ARMY AND NAVY.

U. S. ARMY, FROM DECEMBER 17, 1893, TO DECEMBER 23, 1893.

Aydegger, J. A., Asst. Surgeon; granted leave of absence for fourteen days. To rejoin station, Pittsburgh, Pa., Dec. 7, 1893.

Stewart, W. J., Asst. Surg.; granted leave of absence for fourteen days, Nov. 27, 1893.

Strayer, Edgar, Asst. Surgeon, granted leave of absence for seven days, Nov. 27, 1893.

Oakley, J. H., Asst. Surgeon; to proceed to Halifax, Nova Scotia for temporary duty, Nov. 24, 1883. To proceed to New York, N. Y., for temporary duty Dec. 14, 1893. To proceed to San Francisco, Cal. for duty, Dec. 16, 1893.

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### SPASMODIC TORTICOLLIS AND ITS MEDICAL RELATIONS.

F. X. DERCUM, M. D., Philadelphia.*

Before a body of learned specialists, an elementary review of the subject of torticollis would obviously be out of place. Certain facts, however, owing to the paucity of our knowledge on the subject, demand repeated and careful consideration. Ordinary fixed wry-neck, is of some interest to the neurologist inasmuch as most of the cases owe their origin to some primary disease of the muscles, generally the sterno-mastoid. As a result either of congenital lack of development or of trauma received during birth, the sterno-mastoid of one side is shorter than its fellow, and at the same time is rigid and sclerosed. That, however, fixed wry-neck is not always to be ascribed to this cause is shown by cases reported in which the affection was due to a tonic spasm of one sterno-mastoid, the spasm in turn being due to, or associated with, some affection of the eyes. Wadsworth (Trans. *American Ophthamological Ass'n.*, 1889, p. 381), reports such a case under the title of "Spasmodic Torticollis Apparently Due to Faulty Position of the Eyes and Cured by Tenotomy." Landolt (*Bull. Med.*, 1890, IV., 573), records two cases, one associated with paresis of the left superior oblique and another associated with paralysis of the fourth pair of nerves. Inasmuch as both cases declined operation, the causal relation of the eye symptoms could not be determined. Of the three cases reported, two occurred in young children and one in a girl of seventeen. All had existed since early infancy. These cases are important as indicating a possible relation of cause and effect existing between torticollis and eye-symptoms in children. That, however, some of these cases are due neither to eye troubles, nor to trauma received in childbirth, nor to faulty position of the head in utero, but are really due to defective development, is made probable by the observation of Osler (*Archiv Pediatrics*, 1892, p. 81), who noted the association of congenital wry-neck, with marked facial asymmetry.

*Spasmodic Torticollis* is an exceedingly interesting affection, because of the numerous and varied character of the problems which it presents. We know little of the physiological action of the motor nerve cells, and of muscular tissue, while of the pathology of spasm we know still less. There is probably, further, some good reason why local spasms predominate in the regions of the face and neck, but all that we could say at present would simply be speculative.

Regarding spasmodic wry-neck, we must, it seems to me, admit the following propositions: First, spasmodic wry-neck, is not necessarily spinal accessory spasm. While it is true that the sterno-mastoid and trapezius are decidedly involved in the majority of cases, the spasm is frequently not limited to them, but involves other muscles. Further, cases are on record in which no spasm in the spinal

*Clinical Professor of Diseases of the Nervous System, Jefferson Medical College.

accessory distribution was present at all, and in which, notwithstanding, rotatory spasmodic movements of the head occurred. Again, muscles other than the rotators of the neck may also be involved. Secondly, the constantly recurring rotation of the head is at times the outcome of purely local conditions, and in that sense is a local spasm; at other times, though more rarely, it is the outcome of the action of physiologically associated centers in the upper cervical cord and medulla, or, more rarely still, of the morbid action of a motor centre in the cortex, and in this sense resembles a volitional movement. Both of these propositions seem to me to be of great importance.

Regarding the first, it is frequently possible, by the careful study of the movements of the head, and of the action of the muscles of the neck to determine which of the muscles are actually at fault. However, this can often be done only approximately. The first point is, of course, to determine whether or not the spasm is limited to the spinal accessory supply. If not, what other muscles are involved. The importance of this study, in view of operative procedures, cannot be overestimated, and doubtless is one of the reasons why some cases of resection of the spinal accessory nerve are successful and why others fail.

Having carefully studied the movements and the muscles involved, the next point that suggests itself is to determine whether the case presents physiological associations of different and distant muscle groups. This association is seen at times in the concomitant spasm of both trapezii, and of the anterior belly of the occipito-frontalis, or of the elevators of the upper lip. There is present at times, also, an associated movement of the arm on the affected side. If this movement be in extension and pronation, it is probably a physiological association. Though of great importance, it is not always possible to differentiate between a purely local spasm and a movement indicative of some perversion of the normal physiological action. If such a differentiation be possible it is of the utmost value in suggesting to us the position of the lesion, if any. From what we know of facial spasm, we have a right to infer that the lesion may be situated either in the cortex, lower nerve center, or in the nerve trunk. It is probable that the larger number of cases, with which we have to deal, are cases in which either the grey matter of the upper portion of the cervical cord and medulla is involved, or in which the nerve trunks of the spinal accessory, or of the cervical plexus are at fault. Certainly if the cortex were more frequently affected, we should expect, as Gowers points out, associated movements of the eyes These are practically never observed. It is true, however, that other associated movements, especially movements of the arm and forearm are very suggestive of cortical disease. Pressure points, so frequent in facial spasm, are, as is well known, rare in torticollis, nor do we often have painful points over the spinal accessory or other nerves. Such a painful point was present in a case for a time under my observation, and was situated over the spinal accessory nerve. The subsequent history of the case, however, the nerve being excised, proved that the case was not one of purely accessory spasm.

Regarding the various medical measures for treating these cases, it is hardly necessary that I should go into detail. All present are familiar with the utility of such drugs as gelsemium, conium and morphia—and also their failure to cure—at least, in the vast majority of cases. It is hardly necessary that I should dwell upon the various other agents at our disposal—massage, electricity, and rest in bed—as they give only amelioration and fail to cure. It is to the surgeon that we turn, sooner or later, with the hope of securing for our patient decided, if not absolute relief.

Those who follow me this evening will, of course, have a great deal to say about the various surgical procedures that have been instituted. Certain facts, however, present themselves for mutual consideration. First and foremost of these is section, or rather ex-section, of a portion of the spinal accessory nerve. This expedient yields in a large number of cases marked benefit, and in some instances it is followed by a complete disappearance of the spasm. In three of my own cases, however, it gave comparatively slight relief, the reason being, doubtless, that the spasm was more or less generalized, other muscles being involved. One of these cases I had the opportunity of following up, and later, at

my suggestion, Dr. Keen operated upon her, resecting the posterior divisions of the first three cervical nerves. The operation had originally been suggested by Dr. Wier Mitchell. This expedient was followed by a very decided relief, though at last accounts the spasm had to some extent returned.

We can readily understand why if the spasm be very much generalized—if a physiological movement be represented by it—that the number of muscles involved may be very great. Thus, in addition to the trapezius and sterno-mastoid, some, or all, of the following muscles may take part: the splenius, the rectus posticus major, the rectus posticus minor, the trachlo-mastoid, the complexuses, the obliquus capitus superior, the obliquus capitus inferior, the semi-spinalis, the semi-spinalis dorsi and the multifidus spinæ. This array of muscles shows the utter hopelessness of securing absolute or permanent relief in some cases by any operation on the peripheral nerve trunks. However, such operations should always be attempted provided the case be not clearly proven to be of cortical origin.

It is both interesting and gratifying to learn in this connection that Dr. Keen's operation has been successfully repeated by Dr. C. A. Powers (N. Y. *Med. Jour.*, 1892, page 253). The patient was one in which there was very little involvement of the spinal accessory supply. Dr. Powers adopted the expedient of Dr. Keen, and the result was a complete cure. Mr. Noble Smith (Spasmodic Wry-Neck, London, 1891), has also performed the operation with a successful result. The recurrence of rotatory spasm after such extensive resection of nerve trunks as was practiced on the case reported by Dr. Keen, seems to point to the cortical origin of the disease. The propriety of a cortical operation in such a case naturally suggests itself and deserves serious consideration. The centre for the rotation of the head being situated, approximately at least, in the posterior portions of the first and second frontal convolutions just in advance of the arm centre, it would be, surgically, very accessible and could probably be electrically determined at the time of operation. Inasmuch, however, as the centre for rotation of the head and neck appears to be closely associated with that for conjugate deviation of the eyes, such an operation should only be contemplated as a dernier resort.

Regarding other surgical procedures, such as stretching of the spinal accessory nerve, or tenotomy of the sterno-mastoid muscle,—they merely deserve mention. They are little more than makeshift expedients. However, an operation devised by Collier (*Lancet*, 1890, I, page 1354), deserves special mention. Collier, it will be remembered, tried the effect of a ligature upon the spinal accessory nerve. The ligature was a silver wire and was twisted with sufficient force to lightly compress the nerve fibres. Strange to say, the expedient was entirely successful, the spasm ceasing absolutely. The same expedient was, however, repeated by Drs. Mills and Deaver with failure as the result.

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Dr. Thomas H. Manley, surgeon of the Harlem Hospital, New York, read a very interesting paper before the section of railway surgery at the Pan-American Medical congress on "Torsion and the homologous ligation of divided arteries." After treating the subject in his thorough, scientific and practical manner, the doctor makes the following conclusions:

Whether homologous ligation or obturation of arteries, the former by a living tissue and the latter by torsion of the vessel, possess any enduring value, experimental work and clinical observation alone will decide. Torsion is a very ancient expedient, which suffices for the diminutive and superficial vessels, but for those very deeply lodged or those of very large caliber, it has not been very generally trusted until recent times. Since the attention of the profession has been called to the subject by Professor John B. Murdock, who has revived it on a large scale, and has shown that with the perfected technique, with modern dressings and the elimination of suppuration from fresh wounds, its application has a very large field. As for homologous ligation, I am firmly convinced that with the onward march of progress in the near future, the question of perfected hemostasis will be definitely settled. Time and opportunity permitting, it will be my aim to continue my experimental work, and test to the fullest this species of automatic obturation in the human subject, and report final results later.--*Buffalo M. and S. Jour.*

# COMMUNICATIONS.

## TREATMENT OF VENEREAL BUBO.

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In considering the treatment of venereal bubo we must give careful consideration to the exact condition of the glands when the case is presented, also to the cause of the bubo. By venereal bubo we understand any inflammation or enlargement of the lymphatics of the groin, dependent either upon gonorrhœa, chancroid or syphilis. We will therefore consider the treatment in the following order: First, sympathetic inflammation of the inguinal glands from gonorrhœa or chancroid. Second, virulent or specific bubo. Third, the indurated bubo.

In treating the usual form of bubo from gonorrhœa or chancroid, namely, sympathetic inflammation of the inguinal glands (I use the word "sympathetic" for want of a better one to express the meaning), all steps should be taken to subdue the inflammatory process. First, by relieving the cause, viz, gonorrhœa or chancroid. Second, by such direct application to the glands as will tend to lesson the inflammatory process. First, then, I should advise absolute quietude, rest in the recumbent posture, with the constant application of ice to the inflammed gland. Also an injection, with a hypodermic syringe, of a one per cent. solution of benzoate of mercury, which seldom has to be repeated. If necessary, it may be injected again five or or six days later. If circumstances are such that the patient cannot be kept still, I should use the benzoate of mercury, advising the patient to apply ice with the ice-bag as often as possible. Sixteen drops of the one per cent. solution should be injected well into the substance of the gland, and a compress bandage should be applied and renewed twice every twenty-four hours. Welander, of Stockholm, claims ninety-one per cent. of cures of all buboes which had not reached the stage of suppuration, with this treatment. Letnick, of Odessa, out of one hundred and forty cases, claims complete resolution in one hundred and twenty. In the remaining twenty suppuration had begun before treatment was commenced, and he was compelled to incise the tumor. He proceeded as follows: Having made antiseptic the inguinal region, sixteen drops of one per cent solution of benzoate of mercury was injected into the swollen glands. Then a compress bandage, consisting of antiseptic cotton and a linen bandage was applied. The patient was required to observe the most perfect quietude during the entire treatment. I deem it unnecessary to even mention the many other methods that have been resorted to in venereal bubo to avert suppuration, since statistics show results from this plan which far excell all others.

If a bubo has not reached the point of suppuration when a patient presents himself, every effort should be made to prevent it, but if we fail after six days it is useless to try longer and we should encourage suppuration and bring it on as quickly as possible. When suppuration has taken place, and we have a soft fluctuating tumor, the gland should be incised, making an opening sufficiently large to allow the ready and easy emptying of its contents. The cavity then should be thoroughly washed out with hot sterilized water, using a small syringe for the purpose. Then inject a one or two per cent. solution of nitrate of silver and apply a compress bandage. Afterwards the cavity should be cleansed twice daily with a hot boric acid, or bichloride of mercury, solution, or with fresh peroxide of hydrogen, and iodoform, iodol, aristol or europhen thoroughly applied. While it would be better to keep the patient absolutely quiet for a week or ten days, it is not a necessity. The majority of patients will not submit to it, but attend to their business without serious inconvenience.

Dr. A. Cavazzani, of Venice, recommends the following powder as a dressing after the incision of suppurating buboes.

℞ Iodoform.....Ivss.
Salicylic Acid
Subnit. Bism.....āā 5ij.
Pulv. Camph.....3ss.
M.

The advantages he claims for it are: 1st. It prevents shrinking of the edges of

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the wound, so frequent with iodoform, and which so greatly retards cicatrization. 2d. It rapidly deterges the wound and almost completely suppresses suppuration. 3d. Under its influence the inflamed and tumefied glands rapidly diminish in size, and granulations spring up in abundance, in consequence of which cicatrization is greatly hastened. In many cases where suppuration has been slow and the glands have been inflamed a long time, it is well to curette after the pus is evacuated, but this is not often necessary.

Pontan treats suppurating buboes by puncturing the tumor, allowing the contents to escape, then injecting a ten per cent. mixture of iodoform and vaseline. He claims cure in six to eight days.

Teaclke makes an incision about one-third of an inch in length, through which the contents escape. The cavity is filled to distension with tincture of iodine. The iodine is then pressed out and an antiseptic dressing applied, and over this is placed a large sponge, covering the entire inflamed area. In twenty-four hours this dressing is removed, and all fluid remaining in the sac pressed out and the dressing re-applied. While his treatment is painful, he claims rapid cures.

Wertheim advises puncture of the tumor with a large aspirating needle, through which most of the fluid is drawn, then a four per cent. solution (eight or ten drops) of muriate of ammonia is injected. As the fluid in the cavity accumulates it is again tapped and treated in the same manner.

Zeisse applies compresses wet in a solution of subacetate of lead, and keeps the patient confined to bed. As soon as pus is formed it is evacuated by means of a small puncture. When in spite of drawing of the pus there are marked symptoms of inflammation, the skin is laid freely open, the cavity curetted and packed.

In the treatment of bubo there is no doubt but it would be better to excise the gland as soon as it becomes inflamed and close the wound by suture, thereby getting union by first intention. But circumstances will not often admit of this, as the majority of patients refuse positively to submit to it. Where suppuration has set in, I do not believe that anything can be gained by excision over free incision, curetting the cavity if necessary and applying an antiseptic dressing.

In the treatment of the virulent bubo of chancroid, after free incision has been made, we must regard the cavity as a chancroid and treat it accordingly. Thoroughly cauterize the walls of the cavity with nitric acid and then apply iodoform and a compress bandage. Cleanse and redress the wound twice a day. It is first a suppurating bubo, but after it is incised and its contents emptied, it remains a chancroid.

Syphilitic indurations of the inguinal lymphatics need no local treatment whatever, as they seldom suppurate and gradually disappear under the influence of proper internal medication.

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## GASTRO JEJUNOSOTOMY FOR MALIGNANT OBSTRUCTION OF THE PYLORUS; DEATH FROM ASTHENIA ON THE EIGHTH DAY.

JOHN B. ROBERTS, A. M., M. D.,* PHILADELPHIA.

A man, aged fifty-eight years, presented himself to me with the history of having had some pain in the abdomen and some digestive disturbances for nine or ten months. About four months previously to his consulting me he had noticed a small tumor at the umbilicus, which after a time became slightly ulcerated upon the surface. The tumor on examination was about an inch in diameter and seemed to involve the entire thickness of the abdominal wall; no attachment to deeper structures could be detected. The sallow complexion of the man and his general debility led me to believe that there must be some deeper growth. Examination of the chest revealed nothing especially abnormal, and nothing of importance was detected in the urine. The fact that violent vomiting occasionally occurred led to the suspicion that there might be malignant disease of the stomach and that the umbilical tumor which was evidently malignant was a secondary growth. Investigation of the

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contents of the stomach, obtained by the use of the stomach-tube, showed an abscess of hydrochloric acid in the secretion. Examination by means of the gastrodiaphane gave no evidence of any growth involving the anterior part of the stomach, for the trans-illumination seemed perfect. The vomiting of large quantities of food led me, however, to make a diagnosis that there was some pyloric obstruction.

On October 7, 1893, the interior of the stomach was washed out thoroughly and the abdominal cavity opened for the purpose of exploration and the probable removal of the umbilical growth. Introductions of my finger revealed a tumor about the size of a woman's fist, involving the pylorus and the surrounding structures. As it was evident that the umbilical tumor was unimportant in comparison with the graver lesion of the stomach, I determined to leave the former untouched and make an anastomosis between the stomach and the jejunum. A loop of small intestine was fastened to the anterior wall of the stomach by two lines of continuous silk suture applied according to the method of Lembert. A row of interrupted sutures was then placed at the points where I desired the intestinal and gastric walls to come together in front of the proposed anastomosis. These sutures were left long and the stomach and intestine held apart so as to give me room to make an incision in both organs. At the ends of the proposed apposition, no sutures were applied as I believed I could protect the peritoneal cavity there with sponges until after the interrupted sutures in front were tied. The intestine was kept free from intestinal contents by two pieces of rubber drainage tube passed through the mesentery and loosely tied around the bowel, above and below the site of operation, so as to occlude its lumen.

The gut was then opened by an incision, two and a half inches long, made at a point opposite the mesentery and between the suture lines. The mucous coat was brought into contact with the serous coat of the bowel by whipping the edges of the intestinal wound with a continuous silk suture. The stomach was opened in the same way between the lines of suture, and its mucous and serous covering stitched together by a continuous silk suture whipping the edges. The interrupted sutures applied along the anterior portion of the apposition were then tied and reinforced with an outer continuous suture. Afterward stitches were applied at the ends of the space apposed so that there was no possibility of leakage between the approximated surfaces. The abdominal cavity was then washed with hot water, and the parietal wound brought together. A continuous catgut suture was used for the peritoneum and the skin was united with silk stitches. The umbilical tumor was allowed to remain.

The operation was a difficult one on account of the manner in which the stomach was made immovable by the size of the growth involving its pyloric end. The patient reacted well, though the shock was marked because of the length of time required by the operation. There was some vomiting for a few days, the vomited matter being sometimes dark in color and fecal in odor. At first, feeding by the rectum was employed and the stomach given entire rest. At the end of about three days small quantities of food were administered by the stomach, and dilute hydrochloric acid given to allay the tendency to vomiting. This seemed efficacious and he took a fair quantity of whiskey, peptonized milk, beef-tea, and beef-juice, and retained these articles well. He died, however, of asthenia on the eighth day. For several days before death no vomiting had occurred and food and stimulus were taken quite freely. Strychnine and quinine were administered in the effort to keep up his strength, the quinine being given by the rectum, the strychnine by the hypodermatic method and by the stomach.

An autopsy was made a few hours after death. The abdominal incision was united superficially throughout its entire length. There was no evidence of suppuration and no redness. When the skin was pulled apart with the fingers about a drachm of yellowish fluid was found between the peritoneum, which was united, and the skin; and under each end of one of the sutures was a little hollow about the size of a pea in the superficial fascia. This fluid looked like pus, but was apparently lymph which had filled the space not closely brought together by sutures. The haste with which the sutures were applied because of the patient's depression caused the muscular tissues to be drawn together

imperfectly. As has been said, the peritoneum was united by first intention; and there was no evidence of septic peritonitis in any part of the abdomen. The peritoneal cavity was free from fluid, and the seat of operation was in a perfectly aseptic condition, the jejunum and the stomach being well united. The great omentum was found adherent to the anterior wall of the belly in the left hypochondriac region in front of the normal omental attachment to the stomach. Behind the coil of jejunum which was attached to the stomach by the operation there was room to pass four fingers with ease. The stomach was not much dilated; the malignant growth occupied both anterior and posterior walls, nearly one-half the distance from the pylorus to the cardiac end.

The anastomosis had been made just beyond the diseased area in the anterior wall of the stomach. The jejenum was supposed at the time of operation to have been twisted by me so that the contents of the stomach would flow into the intestine in the direction of the fecal current. The specimen shows that this was not accomplished and that the bowel was not turned as I had supposed. The size of the growth, occupying the pyloric end of the stomach and involving contiguous structures, was about three inches in diameter and irregularly globular. Its size and the infiltration of surrounding tissues account for the difficulty found at the time of operation in bringing the stomach into the wound, although the wound was four inches in length. The omentum was adherent at one or two points along the suture line of the anastomosis on the intestine; for about four inches below the anastomosis and about eight inches above that point the jejunum was somewhat dilated. Some small malignant nodules were scattered throughout the liver, and one or two similar spots of disease were seen on the surface of the intestines. The lungs were not removed, but seemed normal except some pleural adhesions at the apex of each lung. The heart was small but was not opened. The jejunum had been united to the stomach about four inches from its upper end. The union was perfect and the amount of lymph uniting the stomach apparently small. The superficial sutures were visible, particularly at one spot where the bond of lymph had been separated a little by the traction made during the removal of the specimen. The omentum lay behind the coil of jejunum which had been brought up to be united with the stomach. The communication from the stomach into the jejunum was found patulous, but admitted only two fingers from the stomach into the jejunum. There was no evidence of unhealthy inflammation at any point of the operative area. The edges of the opening into the stomach where the suture was used to whip the edges were united, as were the edges similarly sutured in the intestinal wall. The intestine when laid open showed that the communication between it and the stomach was satisfactorily healed on the intestinal side as it had been on the gastric side. The intestine below the seat of opening presented a congested appearance of the mucous membrane. The pyloric orifice of the stomach was contracted and surrounded by malignant masses. It would just permit the passage of the tip of my little finger passed from the stomach into the intestine.

*The most important lesson in the case is the fact that a two and a half inch orifice between the stomach and jejunum had contracted in eight days so that it was only about one and a half inches long and would admit but two fingers.*

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**What the Doctor Gave Him?**

It is not often that one hears a really new medical story, but the following has every appearance of freshness and originality:—Long ago, a man went to Dublin to order a coffin for Pat Connell. "Dear me," said the undertaker, "Is poor Pat dead?" "No, he's not dead yet," was the reply, "but he'll die to-night, for the doctor says he can't live till the morning, and he knows what he gave him." The above anecdote occurs in Mr. Le Fanu's recently-published book, "Seventy Years of Irish Life."

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LUBRICANT FOR CATHETERS.—Castor oil is an excellent material for this purpose. It is non-irritating and tenacious. It should always be applied warm, and the bottle containing it should be frequently washed with alcohol. It can be used for silk and rubber catheters alike.—DR. J. M. KITCHEN.

## THE TREATMENT OF SPASMODIC TORTICOLLIS BY CONIUM.

WHARTON SINKLER, M. D., PHILADELPHIA.

The treatment of spasmodic torticollis is most unsatisfactory. The pathology of the affection is so obscure that rational treatment is all the more difficult of application. Dana, speaking of wry-neck, says: "In rare cases it is cured, in many others it can be ameliorated, but it generally reaches a certain stage, and then remains chronic." Drugs of all kinds have been recommended in the treatment of this affection, and splints and mechanical appliances are not only of no benefit, but usually aggravate the affection. From the fact that frequently the muscles principally involved are the sterno-mastoid and the trapezius, the affection has been supposed to be due to disease of the spinal accessory nerve, and the treatment has been directed to this nerve.

Counter-irritation, galvanism, and actual cautery applied as near as possible to the origin of the nerve, have been used, but with far from satisfactory results. Surgical measures, such as stretching this nerve, and the excision of a large portion of it, have been resorted to, but in only a small proportion of cases has relief followed the operation. It is, therefore, evident that the disease, except in rare cases, involves the deeper muscles of the neck, as well as the sterno-mastoid and trapezius.

Lezynski recommends the use of belladonna, given in increasing doses almost to the point of toxic influence, and keeps this up for four or five weeks. He has had marked success from this method, and Gray states that since he has followed Lezynski's plan, he has cured eight cases of spasmodic torticollis by the use of belladonna. I have used this remedy myself, but without success.

The best results which I have seen from drugs in this disease, have been from the use of conium. This drug was recommended by Harley many years ago, in the treatment of spasmodic affections, but it never has been used extensively. G. M. Hammond reports the successful treatment of a case of painless facial spasm by the use of this drug, and Rockwell, of New York, recommended it in the treatment of chorea. The text-books, however do not speak of it favorably. Hare, in his work on Therapeutics, remarks, "that conium holds an unimportant place in the drug list of to-day." I have found in my own experience, however, that it is decidedly useful in many forms of muscular spasm when not due to central causes.

From experiment, it has been found that conium causes paralysis of the motor nerves when given in physiological doses. There are drooping of the eyelids, staggering and inability to walk, showing its influence upon the muscular system. It is, therefore, reasonable to expect that in the treatment of muscular spasm, when peripheral in origin, that the remedy would prove useful.

Harley recommended the juice of fresh leaves, but this is difficult to obtain and the fluid extract is a reliable preparation. The dose in which it is recommended in the text-books is entirely too small to be efficacious. I usually begin with fifteen or twenty drops, three times a day, and frequently increase the dose to sixty drops. There are two fluid extracts in the market: one of the leaves, and the other of the seeds. I usually give the latter.

I have seen several cases of spasmodic torticollis which were relieved by this remedy, and two or three cases of painless spasm which were distinctly benefitted by it use, in one of which the spasm entirely ceased. I will relate two cases to illustrate the successful employment of conium in spasmodic wry-neck.

CASE 1. Mary C., aged 26, a shirt maker by occupation. Her general health has always been good, and there is no history of special interest in connection with her present trouble.

She applied for treatment at the Infirmary for Nervous Disease, December 12th, 1887. She stated that two weeks previously there began a sense of trembling in the neck, and a heavy feeling in her head. At the same time the head began turning continually to the left side. On examination the head is found to be rotated strongly to the left shoulder. It can be turned to the front but can be held there but a few moments, when it is again rotated to the left. If the head is

held by force in a straight position there are felt strong spasmodic contractions of the sterno-mastoid and the trapezius muscles. She cannot turn her head as far to the right as to the left. There is no pain or tenderness over the vertebræ, soreness in the sterno-mastoid muscle or sensitiveness over the points of emergence of the spinal accessory nerve.

A blister was applied over the point of origin of the spinal-accessory nerve, and galvanism was used quite faithfully for four months; cod liver oil was administered and the patient was advised rest. But little change took place during this time, except that there were two brief periods of improvement, once after the treatment had been changed to the iodide of potassium. At this time the sterno-mastoid and trapezius had become more rigid, and the head after being voluntarily rotated to the front would be drawn to the left within a few seconds by the spasm of the muscles.

The patient was now ordered the fluid extract of conium in ascending doses, beginning with five drops, three times a day, and the maximum dose reached was twenty drops three times a day. This treatment was pursued for twenty days, when the improvement was so great that the head could be held straight for several minutes. The conium was continued until the patient was well, and when seen a few months later, the patient said she was entirely relieved of her trouble. A year latter there was a slight return of the spasm for a few days, but this again yielded, in a short time, to conium.

Case II. Miss G. M., aged 44 years, was admitted to the Infirmary for Nervous Diseases August 28th, 1893. Family history unimportant. She had always been well until four years ago. In November, 1888, while at work she became dizzy and fell, remaining unconscious for a few moments. It was found afterwards that her shoulder had been dislocated by the fall. The dislocation was reduced by a physician within a short time, but there was partial loss of sensation in the arm, and this has continued ever since. The head was turned towards the left immediately after the fall. The left ear almost touched the shoulder, and the head was so much rotated that the chin reached the point of the shoulder. The head remained in this postion for two or three days, when it gradually came back to the normal condition.

After the first fall she had dizzy attacks every two or three weeks; she did not become unconscious, but for a few moments she could not see and would then fall. The head would assume the position above described after each attack, would remain turned to the left for a few days and then resume the proper position.

While the head was drawn to the left shoulder, she could place it in other positions with her hands, but it would immediately return to the position of rotation to the left from the spasm of the muscles. After a time the attacks of vertigo became as frequent as two in a week.

In February, 1893, she had a severe attack, in which she did not fall, but she saved herself by sitting down in a chair. She was not unconscious, and could walk, but became rigid for half an hour. The head was drawn down until it reached the left shoulder. After this attack she was in bed for six weeks, and during this time she states that the whole left side was somewhat contracted. She had no falling attack since February, 1893.

On admission, the patient was found to be a well nourished, muscular woman; digestion normal; heart and lungs healthy; and the urine free from disease.

There is no paralysis of motion and sensation is normal, except in the right arm and shoulder, where it is delayed and diminished to tactile and thermal sense. The knee jerks are normal on both sides. The elbow jerk is exaggerated on the right side, but normal on the left. When sitting up, the head is drawn to the left and rotated so that the chin is turned towards the shoulder. All the muscles which turn the head towards the left, seem to be involved, but especially the right sterno-mastoid and left trapezius. She can turn her head to a normal position but cannot hold it there for more than a few seconds, when it is again rotated violently to the left. When she is lying down, the head becomes almost straight, and the spasm of the muscles does not occur. There has been, at times, a sharp pain in the left side of the neck in the trapezius muscle, but it is now a dull and dragging sensation. The facial muscles have never been affected.

If the patient places her right hand on the side of her head, so as to rest the head upon it, the head will turn to an erect position. The patient was ordered rest in bed, with general massage, faradism to the neck muscles, and the fluid extract of conium, 20 drops, three times a day, to be increased.

On September 7th, that is nine days after the treatment had begun, the patient was taking thirty drops of the fluid extract of conium, three times a day, and it was noted that the head was decidedly better, that she could hold the head straighter, and that when sitting up the head did not so frequently rotate to the left side. On the 14th of September, the patient was still improving. She could hold her head perfectly straight, without support, for a few minutes. She has less of the dull feeling and dragging sensation in the left side of the neck. The improvement continued, and on the 5th of October, the patient was able to hold her head absolutely straight, without any pain whatever. She was discharged from the Hospital, October 16th, entirely relieved of the spasm of the neck muscles, and seemed to be in perfect health otherwise.

Some of the attacks from which this patient suffered were undoubtedly hysterical and it is probable that the spasm of the neck muscles was also of an hysterical origin. The trouble had lasted for over four years, and was not relieved until she was placed under treatment by the use of conium.

## THE HYGIENE OF THE EYE.*

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Next in importance to life itself is the faculty of vision. No man, be he Crœsus or Vanderbilt, would consider his fortune for a moment in comparison with his eyes. How, then, to preserve the eye in a healthy state becomes an interesting question not only to the doctor but to every seeing member of the human family. Preventive medicine has here a field of transcending importance.

It may be said in a general way, that the eye is much affected by the constitutional condition and, therefore, is concerned indirectly in all measures of general hygiene, but it is the special hygienic measures necessary to the preservation of sight that claim our attention in considering this subject.

No feature of face or form compares with the eye in beauty and expressiveness, and as seen in childhood, with lustre undimmed by age or accident and with conjunctiva uncolored by disease or drug, it is to the oculist what the finest of paintings is to the artist.

First in time as well as importance comes the eye of infancy. To produce an ideal child it is said that we should commence two hundred years before he is born—to get good eyes would require equal attention to antecedents. But taking things as we find them, what is our first duty? Immediately after birth the child's eyes should be wiped with a clean cloth (the lids being closed). In bathing the first time, keep the water of the bath from the eyes—then clean them with cloth and clean water, dropping in one drop of a two per cent. nitrate of silver solution. This simple course, if followed by all obstetricians, would reduce the cases of blindness at least ten per cent. This I believe to be the ideal method for lying-in hospitals and for all cases of suspicious vaginal discharge in the mothers. How far it can be employed as a routine in private practice, or what substitute should be used, may be left to the judgment and the conscience of each practitioner.

Attention to cleanliness, general hygiene, and protection from too strong light or other injurious influences, suffice until our babies have become school-children.

In Germany and in some parts of this country, the hygiene of the eyes of school-children has received considerable attention but, in general, far less than the importance of the subject demands. Pre-eminent among the dangers at this stage is the production or increase of myopia

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or "near-sightedness." This may result from prolonged use of the eyes on near objects, especially under unfavorable conditions. It was found in Germany, that myopia increased from twenty per cent. in the lower grade schools to sixty per cent. in the higher. Of 1133 school children whose eyes were examined in New York, less than four per cent. were found near-sighted at seven years of age, but nearly twenty-seven per cent. at twenty years. The practical point in the investigation was the discovery of the unfavorable conditions and their removal as far as possible.

Bad air and excessive heat were found to affect the eye muscles by enfeebling the system, and to indirectly increase myopia by tending to congest the eyes. A still greater factor in this direction is working in an improper position—with the head bent over a low desk, for example. The failure to regulate the height of desks according to the size of the pupils is about on a par with that method of distributing army clothing condemned by Dickens on the ground that "the tall soldiers got the short pantaloons and the short soldiers got the long ones." If desks are too low or of improper slope, or if seats are uncomfortable, the children are likely to lean forward, resulting in the double harm of congesting the blood-vessels and bringing the eyes too near to their work.

Perhaps the most important consideration, here, is the direction and amount of light. Cohn, who examined the eyes of over ten thousand school children in Germany, found 1.4 per cent. of pupils in *village* schools near sighted, and 11.4 per cent. in the *city* schools similarly afflicted, the difference in the proportion being attributed, principally, to the fact that the city schools were darkened by the height of surrounding buildings, while the village schools stood by themselves and obtained light in abundance from all sides. Defective light works injury by causing pupils to bring their work nearer, to make up for the deficiency. Too strong light, or light shining directly in the eyes, irritates the retina and conjunctiva, and also causes too close approach to the desk in bending to avoid the glare. The light should come preferably from the left side.

The kind and duration of work are the other factors worthy of special mention in the hygiene of the eyes of school-children. Small and indistinct print acts much like defective light. Greek and German text are especially trying. Writing with pale ink should not be allowed. Written examinations should not be too frequent. It will be admitted that written work, from its tendency to exactness, is a desirable educationable feature, but it should be employed far less than at present, when it is, undoubtedly, injuring the health and eyes of thousands of pupils and of teachers as well. The hours of study, too, are much too long, and intermissions are too short and too infrequent. Intervals of rest greatly relieve the eyes. If all students were to cultivate the habit of looking up from their books frequently to think over what they have been reading, it would be a source of great mental improvement as well as affording the eyes much-needed rest.

The removal of the above unfavorable conditions as far as possible, according to Von Hippel, has reduced myopia in Germany at least six per cent. In the face of these facts, is it not high time that we were doing something to arrest this growing evil in our own country? The responsibility rests largely with physicians as leaders of society and conservators of public health and welfare. Concerted action under our leadership should accomplish as much here as has been accomplished by the labors of our professional brothers in Germany.

Our school-children graduate and enter different lines of business, each perhaps with its especial dangers to the eye. Stone cutters, machinists, and those in exposed vocations, are liable to various accidents, especially from foreign bodies in the eye. Hence they require some form of protective glasses. These may be of glass, circular in shape, but if we wish to make them unbreakable, they should be of mica or wire gauze; these are, however, open to the objections that they obscure the light to some extent, and, if in the form of goggles, retain the moisture of the eye and hence may increase the irritation. To those whose work requires facing strong lights like the electric arc light, the best protection is in the smoked glasses. These should not be too dark, and should be worn only when absolutely necessary, lest they render the eye more sensitive to light than before, besides causing eye-strain from efforts to see through them.

The habitual use of these glasses from slight and insufficient causes is getting to be a very common mistake, indeed, it might well be added to the list of humanity's self-imposed ills as the "smoked-glass habit." These remarks are, of course, not intended to preclude the use of protectives when needed by actual disease or marked photophobia. They may, then, furnish great relief and even prove curative by affording rest and freedom from irritation. Blue glasses exclude heat-rays and lessen color rays, but give less protection than smoked and are less comfortable; other colors are far more objectionable. Shades, veils and curtains have their uses, also to be governed by the principles already laid down plus such common sense as the special occasion may demand.

In cases of severe disease and after operations, dark rooms may be an occasional necessity, but their bad influence on the minds and bodies of patients being appreciated, they should be used only when unavoidable, and then for but a short time.

Rest should be considered as one of the most important factors in treating diseased or strained eyes; rest of eyes, body and mind. Avoidance of wind, dust and smoke, or protection from their evil effects, must not be neglected.

Personal habits enter into the question of causation of eye disease, and their regulation becomes, therefore, a part of the preventive or hygienic treatment. Sexual excesses undoubtedly contribute to the production of muscular asthenopia and hysterical amblyopia and photophobia, besides affecting the conjunctiva indirectly through their influence on nasal catarrh. Tobacco and alcohol have their well-recognized amblyopias. Lack of bathing the eyes properly may result in conjunctival trouble. Use of water, both cold and hot, may have a place in the hygienic treatment of diseased eyes. Employ, as a rule, that which is the more grateful to the patient: cold usually for conjunctival diseases and injuries; hot for iritic and deeper troubles, avoiding anything like a poultice. Indeed, there should be a limit to cold applications lest the nutrition of the cornea become enfeebled, while that delicate tissue requires still greater care in the use of hot applications (seldom exceeding one hour at a time) from fear of maceration and consequent ulceration. Diet is important chiefly through its effects upon indigestion and general health, which frequently have much to do with the condition of the eye.

A few words as to abuse of eyes may not be amiss. The first offence in this line is reading with a poor light—requiring the cilliary muscle to do extra work to sharpen the vision. This applies to dim light, twilight, sitting too far from the light, etc.

The second offence is error of posture—stooping or lying down congests the eye, besides requiring unnatural work of the eye muscles.

Reading on trains is our third offence, the motion causing such frequent changes of focus and position as to tax the muscle of accommodation as well as the muscles of fixation, so to speak.

Reading without needed glasses or with badly fitting ones is our last, but not least, offence. Aside from the various well-known reflex effects of eye strain, the danger to the eye itself is not to be slighted. Eye strain is certainly a factor in producing disease of almost every part of the eye, its most serious effects being choroiditis, glaucoma and cataract.

Old age is the time of retribution for eye sinners—it calls for little in a special hygienic way beyond the occasional stimulating washes and the careful husbanding of what sight remains.

Fortunately the surgeon's skill can give nearly all sufferers from cataract a greater triumph over their troubles than is afforded any other sufferers whatever, yet it is only after quite a period of darkness in waiting the ripening of the cataract.

In this brief space, exhaustive treatment of the subject is out of the question, but our object has been accomplished if these hints lead to greater attention to an important field which has been sadly neglected.

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A PHYSICIAN who got rid of some of his steel instruments and bought others made of aluminum says that he is sorry that he changed. The aluminum probes, sounds, tongue depressers, and that sort of thing do not oxidize, to be sure, but he finds that they are deficient in elasticity, and stay bent after pressure. He declares, moreover, that he likes to feel as if he had a hold on something when he uses an instrument, and aluminum is so light that it makes him feel as if he could put no trust in it.

# INFLUENZA AND ITS TREATMENT.

CHARLES B. WILLIAMS, A.B., M.D.,* PHILADELPHIA.

Influenza (syn. Epidemic Catarrhal Fever, Contagious Catarrh; French, *La Grippe*) is essentially an epidemic disease, running a specific and definite course and characterized by a catarrhal inflammation of the respiratory organs and sometimes of the digestive. There is pyrexia and a great deal of constitutional disturbance, with marked debility and depression of spirits.

EPIDEMICS.—The first epidemic of influenza that has been recorded in any medical record, occurred in 1510. But there can be no doubt that Aristotle and Galen saw epidemics similar to those which occurred in 1510 and those which at irregular intervals have occurred in our own times. Among the chief epidemics of influenza are those of 1762, 1782, 1787, 1803, 1833, 1837, 1847.

Watson, in his "Annals of Philadelphia," states that Noah Webster in his work on "Pestilence" says: "The city was again visited in 1747, by bilious plague" preceded by influenza. Watson further states that in August and September, 1807, the influenza prevailed in Philadelphia. Then we have the epidemics of the last few years, occurring since 1889, with which we are all more or less familiar.

CAUSES.—The Italians, in the 17th century, ascribed it to the *influence* of the stars, hence the term "Influenza" (Ital., *Influence*), by which the disease is now known. The more probable and more generally accepted theory is that influenza is due to some minute organizm of a specific nature, conveyed by the atmosphere and distributed over wide areas. This organism, when introduced into the bodies of those affected, increases and multiplies indefinitely, and hence we have another source of infection in the breath, etc. Anyone having carefully observed the course of the present epidemic would not venture to question the contagiousness of influenza.

SYMPTOMS:—The period of incubation may last from a few hours to as many days, or may extend to two or three weeks. The disease usually develops suddenly with rigor or chills followed by fever, the temperature ranging between 101° and 103° F. The pulse, at first frequent and full, soon becomes soft, weak and slow. At the same time the patient complains of severe aching and shooting pains in the back, limbs, chest, neck and eyes. Sore throat is a marked early symptom of the disease. Then follow hoarseness, coryza, deafness, dizziness, and sometimes nausea and vomiting.

The local symptoms vary in individual cases, but as a rule they begin in the nose and conjuntivæ and extend downward. There is an abundant watery discharge from the mucous membrane, accompanied by sneezing, with impairment of taste and smell. The mouth, tongue and fauces are sore. The inflammation extends further down, ending in either a laryngitis or a bronchitis, with possible complications of pulmonary congestion, capillary bronchitis or pneumonia.

Some persons are much less susceptible to the disease than others, while on the other hand, some appear to be altogether insusceptible. Influenza can hardly be termed a dangerous disease unless it ends in pneumonia. It is occasionally fatal to infants and to aged people. Then, as so many persons in every large community are "tottering on the brink of the grave," the influenza proves the immediate cause of the increase in the death rate during the prevalence of an epidemic.

The prognosis is especially grave in chronic pulmonary or cardiac disease. Hæmoptysis may not unfrequently occur in those predisposed to it. The writer has seen an example of this occurring in a patient residing in Montgomery County, Penna. The prognosis is also grave where there are evidences of weak circulation, or symptoms of adynamia, as in diabetes, Bright's disease, fatty heart, etc.

TREATMENT:—There is no specific for influenza, but it is possible, and indeed it is often highly important, to arrest the disease, or diminish its violence at its onset.

In the first place, *all* cases should be kept indoors, in a cool room, well ventilated, but free from draughts. If the case is seen early, Pulv. ipecac et opii gr. x., either alone or in combination with Pilocarpinæ hydrochlorat. gr. ¼–½,

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taken at bedtime with a hot lemonade, will do a great deal towards diminishing the violence of the attack.

The above treatment will be found to ameliorate considerably the pains and cough, and the patient will feel relieved by morning. Quinine is a remedy usually well borne, and in combination with Strychnia, gives good results, especially where there is marked debility. The following formula will be found to be of excellent service in this stage.

℞ Quininæ sulphatis vel Cinchonidinæ salicylatis.....gr. xviij.
Strychninæ sulphatis.....gr. ss.
M. et div. in pil.....no. xij.
Dispense in capsul.
Sig. One pill t. i. d.

Should the patient still complain of pain or be restless at night, small doses of ext. Opii may be conveniently added to the above formula.

A prominent symptom of this year's epidemic has been a severe supra-orbital neuralgia, attended sometimes with shooting pains in the frontal sinuses. Indeed the neuralgia has shown a tendency to persist long after the active symptoms of the grippe have subsided. This pain may be due to pent-up nasal secretions or, on the other hand, it may be purely neuralgic. However, the following treatment will usually afford relief: Internally, large doses of the salicylates, preferably, Ammonia salicylatis gr. xv. q. q. h., and the instillation of a drop or two of a 1 per cent. solution of Cocaine hydrochlorate into the nostril of the affected side. If there is occlusion of the nares from pent-up nasal secretions causing pain in the frontal sinuses, then the occasional use of Dobel's solution with the atomizer, may be all that is necessary to relieve the patient.

One can readily see that the treatment of influenza resolves itself almost entirely into symptomatic treatment.

For the bronchitis that usually follows: In the early stages the following formula, advised by Dr. H. C. Wood, is valuable:

℞ Potassii citratis.....ʒss.
Succus limonis.....fʒiss
Syrup. ipecac.....fʒiij.
Glycerinae.....fʒss.
Aquae.....q. s. ad fʒij
M. Sig. fʒij, q. s. h.

Should there be extensive bronchitis and the secretions accumulate, and there are evidences of pulmonary congestion, then Antimonii et potassii tart. gr. ss., may be conveniently added to the above formula. Eucalyptol vel Terebene, m v. in capsul. q. q. h. will also act well in this complication.

Where expectoration has been established and is no longer tenacious, an expectorant mixture containing Ammonium chloride may be substituted for the above.

Alcohol in the form of brandy or whiskey, and best administered in egg-nogg or milk punch, is required where there is much debility and in old persons who need stimulus, from the start of the disease.

The diet must depend on the individual case. Should the case be a severe one, large quantities of concentrated liquid nourishment are required. Usually most patients, in the first few days of the disease, refuse nourishment in any form whatsoever. The writer has found that boiled milk seasoned with a little salt, will be taken and relished by these patients who could not be induced to take any other food.

During convalescence, tonics together with nourishing food and some mildly-stimulating beverage, as wine or beer, are required. Change of air is beneficial, but the patient must guard against taking cold and sustaining a relapse.

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### On Tobacco Smoking.

Gounod loved his pipe dearly. In this connection the following words of his have an interesting bearing on tobacco smoking and its effects:

I admit sincerely the truth of Tolstoi's opinion in all that has to do with the intellectual faculties. I think that the habit of using tobacco produces a sluggishness of these faculties, that this sluggishness follows upon the habit, and by abuse may reach even to atrophy. I am not so sure that it could possibly result in the annihilation of Conscience, whose witness is too startling to undergo so easily an eclipse so disastrous. I say Conscience, be it noted; I do not say Will. Conscience is a Divine decree; Will is a human energy. The latter can be weakened by abuse of the organs; the former, however, seems to me quite beyond all effect of the sort, because it creates the responsibility without which man ceases to be amenable. I have smoked a great deal. I do not recall that it has ever modified the judgment of my conscience on the morality of my acts.—*Review of Reviews.*

# TRANSLATIONS.*

## A CASE OF INCARCERATED HERNIA OF A DIVERTICULUM OF THE INTESTINE.

Dr. E. v. Laczkovich says diverticular herniæ of the intestine are rare, and still more rarely do we find an incarceration of the same. Mery in 1701 was the first to report such a case. Meckel's diverticulum, which can be regarded as the only true one, is formed by a partial opening left from the ductus vitello-intestinalis or the omphalo-mesaraicus, and is found along the ileum about 1 m. from the ileo-cæcal valve. Several other authors have described isolated cases (Walter, 4; Grendig, 1; Gravitz, 1;) in which a diverticulum was found at the jejunum but regarded as identical with Meckels.

In the case reported, a diverticulum of this description was found incarcerated in the right inguinal ring. The hernial sac contained nothing but the diverticulum. The constriction was located beneath the diverticulum, inclosing a portion of the intestinal wall. The case is interesting aside from its rarity, by the fact that the partially gangrenous intestine, was neither reduced nor resected, but following the advice of R. Graefe and Th. Rorsing, it was left outside of the abdominal cavity in its hernial sac, after having released the stricture and removed all constricting tissues.

This treatment was followed by good results, in spite of the presence of greyish spots in the prolapsed tissue and the opaque appearance of the peritoneum. The intestines, on the day following, showed such marked improvement in color and general appearance that reduction could be performed without fear.

The report is as follows:—J. S., age 56, was admitted on September 13, 1892, to the surgical department of the general hospital at Budapest. History was as follows:—On the 9th of September, while lifting a heavy piece of machinery, weighing 50 kg., he suddenly experienced great pain in the right inguinal region, followed by swelling. In spite of the increasing pain, he worked until the 11th, on which day he was unable to get up. After another attempt on the 12th, to continue his occupation, he found himself compelled to go home and go to bed. A physician was called, who diagnosed incarcerated hernia, which he attempted to reduce without success. Careful examination showed a swelling, the size of an egg, in the right inguinal region, painful upon pressure. The skin could be lifted and was of normal consistence. Abdomen slightly tympanitic; some inclination to vomiting; last movement September 9th; pulse frequent and compressible.

Incarceration having existed four days, no attempt was made at reduction of the tumor, but herniotomy was at once decided upon. After opening the hernial sac there was an escape of about one teaspoonful of reddish-brown, opaque, odorless fluid. The sac contained a prolongation of the bowel, about 3 cm. long, 1½ cm. wide; its upper portion was dark red and lustreless, with numerous greyish patches. After loosening the stricture and separating the fibrinous attachments formed in the ring, the intestine was drawn forward, which showed plainly the constricted portion, which was, however, not yet gangrenous. The suspicious appearance of the above-mentioned attachments induced the author to surround the intestine and pack the opening with iodoform gauze, leaving all within ready access. After the operation free movements of the bowel occurred. On the 14th of September he changed the dressings. The intestine, appearing normal, was replaced; drainage tube inserted; wound closed with sutures and dressed with iodoform gauze. Free bowel movements daily. The patient was discharged on the 27th inst., cured.

This case is similar to that of Graefe and Rorsing, and the result being equally as good, affords encouragement to adopt the treatment in such cases where gangrene is not complete.—*Centralb. f. Chirurg.* No, 36. —W.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

## THE PLASTIC FORMATION OF A SPHINCTER FOR THE LARGE INTESTINE.

In the year 1889, the author, Prof. R. Gersuny, Vienna, (*Centralb. f. Chir.*, No. 25,) described a new operation for the correction of incontinence of urine. The method consisted in dissecting from the adjacent parts, the urethra, which was then twisted on its long axis, presenting a corkscrew appearance, after which the urethral orifice was united to the surrounding tissue by sutures. This presented an elastic resistance to the contents of the bladder. The author reported at the same time, the history of a patient so operated upon, and also the persistent cure after a longer period. The only possible objection, if it could be called that, being that the patient required more time to empty her bladder than if she had a natural sphincter.

The success of this operation induced the author to carry out the same theory where extirpation of the lower portion of the rectum, including the anus, became necessary for the removal of carcinomatous degeneration. He presents with history, two cases upon which he performed this operation. He was enabled, after having extirpated the diseased tissue, to draw the bowel down to the integumentary incision, having previously twisted it on its long axis—as he had done with the urethra—and fix it to the skin with sutures.

Recovery was prompt. Union perfect in both cases. Both were enabled to retain even watery stools. Shortly before leaving the hospital, a digital examination was made in each case, which resulted in finding a circular, elastic constriction of the lumen of the bowel, 2 to 3 cm. above the external opening. The mechanism of this closure rests chiefly upon torsion, and its success upon the normal elasticity of the tissue. This is particularly essential if the cures are to be permanent.

A correspondence after discharge from the hospital, brought satisfactory answers, the one eleven weeks, the other sixteen days after having left the hospital.—*Centralb. f. Chirurg*, No. 26. —W.

# SELECTED.

## THE PROFESSIONAL HORIZON.

DAVID W. CHEEVER, A. B., M. D.

*Audi alteram partem.*

The master mariner in olden times scanned the horizon, watched the currents, estimated the tides, studied the winds to guide the good ship on her course. All these were variable and changeable; but the magnetic needle, the sun, moon, and stars were unvarying guides. So the modern steamship master may disregard the winds, surpass the tides, defy currents and storms; but yet he is always dependent on the compass, the quadrant, and his solar and stellar observations for his position, his progress, and his prospective voyage.

Thus, too, the older surgery, contending with obstacles and evading dangers, by its care and skill, although by devious routes, often landed its patient safe at last.

While modern methods, more rapid and direct, may lead straight on to recovery and to life, yet, although newer observations, newer science, newer instruments of precision, may modify and may advance modern surgery and medicine, the principles of the science and art remain the same as they were before; and, if disregarded, they lead to failures in practice, or at best to temporary success.

In scanning, like the old sailor, the professional horizon, may we not learn from the omens of storms or calms, where we have gone astray from the unerring guides of sound professional principles?

The unbalanced predominance of operative surgery has destroyed all natural and harmonious proportion between operations and surgery; and between surgery and medicine. Antisepsis has insured an immunity which over-emboldens the operator, and which substitutes the precipitate certainty of an incision for the well-con-

sidered conservatism of diagnosis and delay. No one can deny that anæsthesia first, and antisepsis next, have enormously increased the domain of operative surgery. No one can assert that much of this is not both useful and hopeful. And yet, in proportion to other surgery, operations should fill a second place. The rare has become the common, and the common has been pushed aside and neglected. Contusions, abscesses, fractures, varicosities, atheroma, are the every-day things we always see; and abdominal diseases have usurped undue attention, and displaced the common classes of surgical events.

Diseases of the joints, affections of the lymphatic glands, maladies of the bones, ulcers, the endless variety of affections of the rectum in modern sedentary life,—these, like the poor patient, we have always with us. Such cases filled the text-books, and supplied a large part of the surgeon's practice. But to-day, if the student or practitioner opens the pages of the present surgical text-books, he finds that genito-urinary surgery and that of the abdomen and the brain occupy one-third of the space. Pages are devoted to the multiple and fancy stitching of an intestine, and a paragraph suffices for piles; yet one hundred people have piles, and require treatment from the surgeon, to one who has intestinal obstruction. The new is interesting, the new is important; but it is overdone. Perspective is lost: the natural proportions of classes of cases obscured. Rare things are magnified; common things are overlooked.

There is also constant danger of confounding functional and temporary with organic and permanent conditions: of operating for a symptom, and finding a phantom tumor. Visceral surgery replaces therapeusis. Forlorn hopes are common operations. Exploratory incisions made for diagnosis may be often innocuous where no disease is found, but are very fatal where organic and incurable affections exist. It used to be said that it was fatal to explore a tumor, outside the body, unless you could take it out. It is equally dangerous and often fatal to explore a visceral tumor, in spite of antisepsis.

Is there not danger, also, that the ease of looking breed littleness of wit; that intuition, that sum of experience, may shrink and waste, when unused; that the balancing of chances, the estimating of probabilities, the struggle for a diagnosis, may be belittled in face of reputed certainties revealed by a cut, and thus delay sober judgment? Is not the therapeutic use of drugs also much unlearned by this fatal ease of operating? Obscure brain affections, nervous habits, apparently organic and incurable growths, sometimes yield to medicine, and escape the knife. We may not often thus succeed; but does not the fact that we do not try medication lead finally to a loss of knowledge as to the chances of a trial?

Specialties magnify regions, distort wider vision, focus the attention on a point and ignore a more important whole. A diathesis, a constitutional bent, often directs or influences the general progress of a disease. A symptom may be local, or general. If local, it is seen; if general, it may be easily overlooked. Habit may perpetuate an epileptic crisis in spite of the operative removal of the local cause of the aura. A vent boldly given to a subarachnoid hemorrhage may not prevent a fatal result due to the plugging of the nutrient vessels of the pia mater. Clots in the spinal canal may be absorbed, sometimes, with less hazard than by removing the laminæ and uncovering the spinal cord.

The treatment of the diseases of women has become almost purely operative. Attention to constitutional treatment is thus easily diverted.

The sexual maniac is spayed, often without lasting relief. Pelvic cellulitis and peritonitis not very rarely are lighted up by hasty interferences with the interior of the uterus.

Life is occasionally shortened by too early removal of innocent growths about the ovaries and uterus. So intensely has the attention been called to the right iliac fossa, that an appendicitis is suspected in every colic; incisions are sometimes made before walling off has occurred; an organ removed which was the seat of only temporary catarrhal obstruction, and the adhesions of an excision substituted for the adhesion of a transient inflammation.

Is any incision harmless? Certainly it is not. A scar is left; sensibility is increased. If in the abdomen, the binding power of the fasciæ is weakened. Hernia may result; or, at any rate, prevention may require an abdominal supporter to be worn ever afterwards. In gunshot wounds of the intestines a certain percentage of

cases may recover without operation. Extravasation may be prevented by the pouting of the mucous membrane through the perforation of the ball; and the latter may be discharged *per rectum*. Of course, the majority die. But so, unfortunately, do most of those operated on. The history of such cases is scanty, the pathology new, the results few. Let us by no means discourage research, experiment, or even operation; but let us make haste slowly.

In the charm of asepsis, in the ease of healing, in the painlessness of operations and of recoveries, we are apt to overlook that great factor, shock. The effect upon the nervous system of a disease, an injury, an operation, is hard to estimate. It often turns the scale against recovery. Especially about the neck; in the three great cavities of the body; in any operation on the extremities which approaches the centre, the results of prolonged and teasing operations are often fatal through profound and prolonged shock. It has been recently advanced that age makes little difference in the prognosis of an operation,—an opinion from which we absolutely differ. No one who has watched the old but has seen prolonged shock of the nervous system, and evidences of impaired mental activity, long subsequent to operations of even moderate severity.

The somewhat ungrateful task of advancing heretical opinions, in the preceding remarks, can be condoned only from our profound conviction that the operative *furor* of modern surgery is resulting in a serious detriment to the best qualities of sound diagnosis, sound pathology, and surgical therapeusis: to diagnosis, because we do not exhaust means of harmless research; to pathology, because we operate to know what is the matter, and not from proved pathological processes and results; to therapeusis, because we neglect much that can be accomplished by regimen, by rest, by sedatives, by alteratives and by time.

When we survey the medical horizon, we find equally great changes. That harmony of knowledge and character which made the general practitioner many-sided, but symmetrical—*Sapiens, teres, atque rotundus*" (Horace); that self-reliance which equalized extremes, balanced chances, judged impartially—have been sadly damaged by the fatal facility of the habit of consultations and by the narrowing spirit of specialism.

A great ignorance of the simpler products and processes of pharmacy has accompanied as great a lack of careful study in therapeusis. The medicine is now made to hand for the doctor by steam and chemistry; and the useful combinations of older drugs are swept aside.

Bred myself in an era of therapeutic nihilism, experience has failed to confirm my unbelief. On the contrary, long trial has convinced me that we can accomplish much with a few, well-selected, familiar and potent remedies.

If the surgeon and physician have changed, the lay public has changed faster. Credulity is undiminished. Modern witchcraft rivals the older kind. Therapeutic nihilism has become a system and a school of medicine. Practice has lost its stability. Formerly there was a family physician, whose patients retained him as a familiar and much-used fixture until he died. Now he shares a family with others; and he does not look on any person as his patient for life. This is a greater loss to the community than to the doctor. We regret, but we yield to these revolutions.

Meanwhile should we take a depressing view of our professional future? By no means; for never was surgical and medical science so bold, so advancing, so successful. Never was the young doctor so well educated as now. Never had he so large a clinical experience before entering on practice.

Moreover, partly from this cause, and partly from the mutable character of modern society, the young physician or surgeon never succeeded so fast, as now.

The future is full of hope. Knowledge advances. Hygiene and preventive medicine prolong the average of life. Zymotics are to be stamped out. Bacteriology is to revolutionize therapeusis.

We, who have once ploughed the land, look back across the furrows of time, and gather new hope, as we see the renewed greenness of the fields of science, cultivated as they have never been before.

Only would we insist on the caution begot of experience, on the value of the past.

Let us advance firmly and with a confident heart, still holding fast to that which is good. The magnet does not vibrate. The sun and stars are eternal in their courses. Nothing can deflect from his course him who studies, hopes, believes, works.—*Bul. Harv. Med. School Asso.*

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SATURDAY, JANUARY 13, 1894.

## EDITORIAL.

### INCREASE OF INSANITY IN THE UNITED STATES.

Statistics are notoriously elastic; that is to say, almost any proposition can be mathematically proved either true or false according as figures may be manipulated. At the same time statistics afford us the only method of measuring any proposition of very extensive and general scope.

The Government decennially takes an account of stock in order to gain information regarding itself. Now the census has been made to include items pertaining to public and private affairs, so that one may almost say the very hairs of his head are numbered. But the census reports can only be regarded as approximate estimates, and not accurate statements of the conditions dealt with.

The last census of the United States indicates that the increase of insanity has been proportionably much greater than the increase of the population. This rapid increase is more accurately demonstrated by the periodical reports of institutions for the insane and of public officials who take exact cognizance of the insane under treatment or care, at definite dates, from year to year. These reports show clearly that the number of the registered insane has much more than doubled during the past two decades, while the census shows for the same period that the population of the United States had gained about sixty per cent.—being about forty millions in 1873 and about sixy-five millions in 1893.

The proceedings of the Conference of Charities at Chicago show by official reports that in many of the States the increase of the registered insane has been astounding. Thus in Rhode Island, where, in 1873, only 150 persons were in the chronic insane asylum, there are now some 600—four times as many; though the State population in the twenty years had gained only from 235,000 to 370,000—sixty per cent. In Iowa the count of the insane went up from 600 in 1873 to 2,385 this year; the population in that period having gained from 1,320,000 to 2,000,000—or fifty per cent., but the insane having more than trebled. In Kansas the population rose from 475,000 in 1873 to 1,500,000 in the present year; but the insane reported twenty years ago were but 200, where now

they are almost 1,500. In New York the gain of population was from 4,600,000 in 1873 to about 6,500,000 this year—less than forty per cent.; but the insane have risen from 7000 twenty years ago to more than 18,000 this year, gaining nearly one hundred and sixty per cent., or four times the general rate. Ohio, with an increase of inhabitants from 2,800,000 in 1873 to 3,800,000 now, apparently shows an increase of her insane from 3,147 to 8,500—one hundred and seventy per cent. as against thirty-six per cent. gain in the total. But of all the States Illinois gives the greatest proportionate surplus of insanity; for while her population gained from 2,700,000 twenty years ago to 4,050,000 now,—fifty per cent.—her registered insane, according to the Conference report, went up from 642 to 4,867, or a gain of six hundred and sixty per cent.

These reports, of course, are only in general terms, and may be full of unrecognized errors; but they are correct enough to evidence the general fact that insanity is on the increase.

The causes of this increase are numberless and are not restricted to any locality or, indeed, country. It is believed that a similar increase is shown among all civilized nations. These facts are of direct interest to physicians by virtue of their profession; especially so is the conclusion that seems inevitable—that chronic insanity is virtually incurable.

## CORRESPONDENCE.

EDITOR OF THE MEDICAL AND SURGICAL REPORTER:

I have read attentively the letter of your correspondent in the issue of December 23, on "A plan to remedy the dispensary abuse," and I regret to find no suggestion as to a remedy for the abuse.

Your correspondent dismisses the subject with the assertion that "there is no reason why the general management of the dispensary system should be disturbed," thus leaving the matter just where it has been for a long time, and if the members of the profession are satisfied, there is no reason why the writer should not be.

The subject is not one in which the writer is *personally* particularly interested, and his only motive in considering the matter at all was in behalf of his professional brethren.

It is all very well to clamor for reform, but if we stop there, what have we accomplished?

What we want is a practical plan upon which to *work* for the desired reform, and it was with this view that "A plan to remedy the dispensary abuse" was proposed, with no idea that it was perfect!

It seems to some after carefully reading the scholarly letter of your esteemed correspondent, that our proposed plan with modifications and elaboration, might be made to cover many of the abuses which he so ably and truthfully portrays in his letter.

There can be no doubt that we need "organization" and "discipline" to accomplish anything, and it was with the hope that our medical societies would take the matter up for consideration, that we ventured our suggestions. We still hope for criticism of our plan and for suggestions as to a better scheme by which the profession can be helped.

Nothing but prompt and decisive action will be of any avail, and who will take the initiative?

It is easy to exclaim, "*impractical,*" but let each one propose a better plan, then we may expect from the multitude of counsel to formulate something that will meet the case to the satisfaction of all, but we cannot anticipate much help from those who are selfishly interested in continuing the abuse. I hope to hear from more general practitioners in regard to the subject which should be of great interest to them.

Fraternally yours,

ALFRED K. HILLS.

December 29, 1893.

# ABSTRACTS.

## SICKNESS AND PAUPERISM.

L. L. BRYANT, M. D.*

There are over 8,000 histories of families who have applied for public aid on file in the office of the overseers of the poor in this city, This represents 24,000 names, in round numbers which appear on the pauper books of Cambridge. To this list, names are continually being added at the rate of 1,500 a year. What are we, as a Society, doing to prevent this? The question has often been asked me: "What are you doing?" and I have many times propounded the same question to myself. This paper is written in the effort to reply. In the month of May, 1883, ten years ago, I was elected to the office of Assistant City Physician. The said office was created December 1, 1880, to enable the local Board of Health to conform to statutory law and yet retain the incumbent City Physician, Dr. Henry P. Walcott, a man occupying an honored position in the State Board of Health, and standing deservedly high in the respect and esteem of the people, and of this Society, of which he is a member.

My predecessor, Dr. O. C. Turner, a most estimable man, died in October, 1892, of typhus fever, contracted while in harness; and during his illness, and subsequently until my election the affairs pertaining to the office were satisfactorily conducted by my friend, Dr. Wetherbee.

With a nervous organization particularly susceptible to external influences, and with absolutely no knowledge of the refinements of modern economics as applied to the poor, I sought and found the office which I still occupy; and my only qualifications were a fair knowledge of general medicine, and that experience which usually follows the first few years of practice subsequent to graduation.

The gaunt, hollow-eyed, cadaverous poor, having nothing and wanting everything, I knew nothing about, and as little what to do for, or with. Entering the service of the city under the circumstances, and in the conditions mentioned, I first made myself acquainted with the duties prescribed by the city ordinances.

I found the office of the overseers of the poor to be the abiding place of one of the most perfect systems with which I had ever been made acquainted, with its thousands of histories of individuals, each one necessary to the proper registration of an applicant for aid and the establishment of a legal settlement, numbered, indexed, and filed away in bound volumes. I found in this office all the usual machinery and labor-saving devices necessary to the conduction of a large business, and presided over by a secretary, D. P. Muzzey, devoted to his work; and apparently constantly employed. I found that all appeals for assistance must be made to this secretary, who was empowered by the Board to dispense the city funds at its command as it deemed for the best interests of the applicants, and then to so manipulate the official machinery in the interest of the city as to secure from the various cities and towns wherein they had resided long enough to acquire a settlement, a monetary equivalent for everything paid out and for all services rendered. I found that the fixing of a settlement on some other city or town was one of the most important duties of the office, and required the service of a so-called "visitor," who, likewise, was apparently constantly employed. This labor necessitated calling on the applicant, asking for, and recording various personal questions, searching city and town records to prove the truth or falsity of his or her statements, and, in general, the making of such a return to the office as would enable it to form as accurate an idea as possible of what he had been, what he was, what he wanted, and how we are to get anything back?" I found that the secretary was the confidential clerk and advisor of the Board, the disburser of supplies, and came into more intimate relationship with the Board, the poor, and the general public than any one else, and conscientiously performed his duties.

The visitor, Vespasian Danforth, enjoyed the distinction of being considered one of the best versed men in pauper law

*Assistant City Physician of Cambridge, Mass.

in the State. Both of these public servants were ever on the watch for fraud, and worked the machine, seldom allowing sentiment to change the order of its working. Not but they were susceptible, but experience continually taught them that yielding to it was an unprofitable indulgence save as a reflection from the Board. I found as a working formula that the overseers of the poor expected me to visit such of the poor of the city as the secretary should direct, prescribe for them as my judgment dictated, and to suggest to the office anything which I might consider to be the policy of the city to do in the direction of relieving their sufferings and distresses, or tending towards making them better law-abiding and self-supporting citizens.

Of all classes, the poor seem to be the one easiest to prescribe for, their wants being few and simple, and one's mistakes are so easily buried. I went into the work largely for the salary I was to get. I did not love the poor, that I can remember, except in an off hand sort of way, and I am not certain just how much I have acquired; but I soon found that there was something more for me to do than to issue dogmatic instructions as to medicine and diet. These must often be furnished; and not alone diet and medicine, but everything my patient's condition sets up within me the want for him to have, but there was more than this.

The labors of the Board, with which I was connected, were not only directed toward relieving paupers, but toward the prevention of pauperism. The more I became acquainted with the office and with its efforts in this direction the more apparent became the responsibilities which I had assumed; and often, as the magnitude of the efforts of others in charitable work have become known to me, my own have seemed so futile, that a morbid sense of my unfitness for the work that was gradually unfolding itself oppressed me. To-day, all the Utopias of which I may have dreamed, are vanished. I feel that I have acquired what the boys call a "crust," from off which smiles, tears or curses alike glide, and if ever unpleasant reminiscences assail me I pull myself up out of the pessimistic slough, with the comforting thought that I have done my duty as I have seen it, and have earned my salary.

The man in private practice has his pensioners to whom he gives or withholds according as his emotional centers are affected. Nowhere have I found such tenderness, devotion, sacrifice, and forgetfulness of self, as that exhibited by the members of the medical profession, particularly for the worthy poor; those unaggressive individuals whose morals, or "rules of conduct considered essential to social existence," appear like ours and have not altered under poverty's pressure; those who suffer and are still, and who practice virtues we do not ourselves possess. This is often, however, but the chrysalitic or transition stage preceding their development or degeneration into the unworthy class.

The unworthy poor are those who do not approach or appeal to the average medical man as he fondly imagines that he would, were he in the same financial condition. There is an aggressiveness and an insolence about them that is repellant, and which gives one the impression that the same force economically applied would make them independent of others' assistance. But the law knows no such distinction; sickness levels both to the same plane, and as the medical officer of the city the fact that I am to care for any one being established, I have nothing to do with his morals except where their defection is the cause of his disease, and must use the same circumspection for all alike.

Upon going out into the homes of the poor, I found there the hard, coarse, hellside of life. I found as types, the nice old lady who wouldn't for the world have her friends know that she felt obliged to have the city doctor; the tired-out, exhausted, poorly-feed, discouraged laborer; the thin, hatchet-faced mother, daily rubbing her very life into the washboard, while the father stays at home and minds the babies; the broken-down beat and bummer, with his trembling muscles and his protestations of sobriety; the sick infant, left to the care of one scarcely older than herself; the dirty, lousy syphilitic; the consumptive and chronic rheumatic, waiting for and looking forward to death; the criminal imbecile, fool and insane man; and the little children prematurely aged and kept at home at scullion's duties. Seldom I found the square, honest, upward energetic look, but oftener, the inert, downward, sneaking, leering glance, with the light reflected from the white of

the eye. Here a woman asserts that she is sick, that her husband has rheumatism, or that her child has a contagious disease, that I may be induced to request of the office, fuel or groceries. Here is an intelligent man of the genus tramp. I met the same man last year, and the year before that. The nights are getting quite cool now, and he concludes that it is about time to go into winter quarters. Leisurely he makes his way to the office, and informs the officer there that he would like to go to the almshouse. Asked why he does not go to work he replies with an injured air that he has a pain in his back and cannot work. The officer demurs. The man grows persistent, and is finally referred to the doctor. The injected superficial veins and his general tremulousness tells their own story; but what about the pain in his back? Is there one of you here who is able to tell whether he has, or has not, a pain in the back? You are morally sure that he is a fraud; but who of you having the power has the courage of his convictions, and will say to that man, "No." No; public sentiment has not reached that stage where it will support any such decision, and we think again, and we find that it is true that he is not quite "up to concert pitch;" that he does need a little straightening out; and a doubt begins to frame itself that we have all the factors relating to that pain clearly before us, and the man goes to the almshouse.

Here the best that the house affords is his; food, clothing, bedding, pipes, tobacco, and that luxury of the modern hotel, a smoking room. Here in this steam-heated shelter, he whiles away the short winter days, sleeps through the long restful nights, grows fat, and perhaps, when the snows have gone, and the spring is well advanced, he ties up clothes in a bundle that he did not fetch with him, tells us that he has found work, and bids us adieu.

It is no state secret that public officers are largely at the mercy of a class of persons made sharp, keen and desperate by their fancied necessities, who are more difficult to manage than criminals because they are not under the ban of public censure, but hiding under the wings of public sympathy are in the position to dictate and the officers must obey. That this is true abroad as well, is asserted by Josiah Flynt in the October *Century*, who says of Germany, the home of the most-advanced public efforts relating to pauperism to-day: "With all its groans under taxes, military and otherwise, it nevertheless takes upon itself voluntarily the burden of the voluntary vagrant—the man who will not work," and after giving a resume of the various methods and institutions employed, he adds: "But the man who will not work passes through these institutions as freely as the man who will."

And now, what shall I do with my patient? The therapeutics of pauperism, complicated with sickness, is somewhat different from that employed where treatment is confined to sickness alone. Both are morbid conditions, and either or both may be inherited, or acquired, or contageous. Both must often be treated at the same time, because if the treatment be limited to one, fatal results may accrue from an aggravation of the other. Together they make up a combination that in spite of the prayers, labors, study and money used and continually being used, is frightfully on the increase. When I do not know what to do I fall back on the machine. When I can care for my patients at home, I do so. When it is a question of hospital or almshouse, I send him to the almshouse. Why? Because it is cheaper. Surgical cases go to the hospital, because they have the appliances, and can command the skill which I do not not possess.

As the years have gone by, I have been led to look into the "springs of man's action," in search of the causes of pauperism, and for additions to my armamentarium. I have found the truth of Bastiat's observation, that all economic movement may be resolved into "wants, efforts and satisfactions," terms correlative of those of the reflex process of ideation; perception, comparison and action. Want, according to Gunton, is "such conscious need of an object that its absence will cause sufficient pain to induce the efforts and sacrifice necessary to its attainment." "Want is the sole motive, and the only measure of effort, for no more effort is ever put forth than is necessary to secure satisfaction. Until a desire becomes so intense that more pain is produced by its non-satisfaction than will result from the labor and sacrifice involved in its gratification, it is not an economic

force of want, the need to consume being too weak to impel sufficient effort to produce."

I found that man's efforts tended towards the achievment of satisfactions that are "customary, and therefore demanded" by the best livers among those with whom he associates, the sum of which constitutes his "standard of living."

I found that perceptible advancement in one's standard of living was not a matter of days or months, but of years; and that any attempt to force its growth met with waste.

I found that the standard of living of the poor with whom I came in contact was not mine, was best ascertained by comparison—not with mine—but with those of a social equality with them, and that their efforts were then more intelligently directed along economic lines.

I found that history teaches that public aid does not strengthen but weakens, and breeds the disease called pauperism.

I found that it was not expected that this people should remain paupers, but that their necessities should force them to continue their efforts to keep up in the race.

I found, as Stoddard puts it, that "not what we would, but what we must, makes up the sum of living," and that sickness, sighs, tears and groans were not economic forces, but media through which one's ineffectual desires and efforts were communicated to others.

Physical disease is a common foe, without sentiment, smiting alike the rich and the poor who disobey the inexorable laws of health. Money will not propitiate it, years of penitence and years of prayer have not stopped its devastating onward march, and it is only when we add the sick man's ineffectual desires to our economic wants, and let our strength compensate for his weakness in a common struggle for a common satisfaction that sentiment is of value as a therapeutic agent. It is not the empirical sentimentality that gives birth to flowers, ice cream or religious tracts, but the kind that reaches down, grabs you by the hand and stands shoulder to shoulder with you in a *fight* with a common enemy.

I have found the same is true in the treatment of pauperism. It is not pity that comes in with tears, sighs and groans with which to fight tears, sighs and groans, but that coming with the trumpet call to arms. There is a sentimentality, and affectation born of ignorance, money and fadism with which we all are acquainted. It looks right, but it rings flat. It takes a man up, toys with him until he ceases to be a plaything and refuses to be wound up, or to run right when he is, then it tires of him, and he is told that if he wants any more assistance to apply to the overseers of the poor. What can the poor devil do? Go to work? Where? What is the incentive to work? No, he has eaten of the tree of knowledge, his ambition and energy are sapped, his moral tone lowered, he cries inertly: "God help me, what can I do?" and he lets his wife and children work. He applies to the overseers of the poor and contracts pauperism. His children are taken sick. He is informed that he can have free medical attendance by application to the city doctor. Is his condition improved? Is the material condition of his family improved? Not as I see it. Down he sinks, lower and still lower in the social scale until, as the years come and go and his children reach the age when they should be self-sustaining, they too think and act along the same lines, and have an incapacity for economic effort. A glance at the histories on file in the office of any board of overseers of the poor will show this to be true, as will also a perusal of the history of the notorious Jukes family.

And now, what can be done to prevent a continuance of this state of affairs? Make no distinction as to worthiness or unworthiness, and keep the people from going to the overseers of the poor. That the men of some sections of the city are doing this I know, from the few calls I get in their locality.

As physicians we can not afford to shirk the responsibility which is clearly ours, by every law of scientific and human right.

We are scientists, striving to look through the maze or error and to discover the truth.

We are philanthropists by virtue of our profession, intrusted with the lives and the material happiness of our fellows, poorly paid for our services even by the wealthiest, and looking forward to the close of life, not with the expectation of leaving a large account to our descendants, but an example for their emulation.

We are optimists, too, ever looking for the best principles that move mankind. We come into closer relationship with humanity than pastor, priest or law-giver. Ours is the opportunity possessed by no other body of men, to inculcate those principles of thrift and independence which are the essence of true manhood, womanhood and American citizenship.

The individual study and applied efforts of each in a few instances will produce better results and more lasting satisfaction than with many.

In my own case I aim at quality and not quantity. I am not at all anxious to present a list of a large number of patients in my annual report.

When a man comes to me to be inoculated with pauperism and informs me that such a doctor always attended his family, but that he owes him a bill and is ashamed to ask him for further assistance, I send him at once to his physician; and I instruct him to tell his doctor his whole story, concealing nothing; and then to say to him: "Doctor I have no money, but just as soon as I can get work I will pay you a little at a time until my bill is paid." I have never know such an effort to fail.

A little story of Marshall Wilder's I sometimes use a therapeutic agent: "Two frogs fell into a pail of milk. One exclaimed: 'Help! Help! I sink! I drown!' The other answered gruffly: 'Kick! Kick; you little devil! Something will surely happen.' The first one continued to gasp and moan, and finally sank out of sight. The other kicked and kicked until nearly morning, when the milk having been churned to butter, he waked out into dry land."

DISCUSSION.

Dr. Morrill Wyman said he had not seen as much pauperism as the reader, yet he had had considerable experience with it. He told of one case rather remarkable, where the father a miserable fellow, became a pauper and the succeeding children, making three generations, followed his example. In the early days of practice there were few foreigners in Cambridge as compared with the present time and there was less pauperism.

Seeing a number of lazy looking fellows loafing about a corner, only a short time ago, he accosted one who was smoking and asked how these men obtained a living; when he received the reply that their parents went out to work and their mother took in washing. When asked what was to become of these men the fellow replied: "They will bring up in jail if they are lucky enough to escape hanging."

Dr. Hoarce Marion said the reader had presented in a forcible and illustrative manner may stubborn and stony facts. The subject is a broad one to grasp on which little literature has been published, and with foreign countries pouring in a constant supply of pauper, one of great moment for the welfare of this country. It is difficult to say what is best to be done, but it is certainly sure and important that patients should be kept away from the overseers of the poor.

The emergency societies are doing much to prevent the development of pauperism. Their method is to practically give them the articles they require, but at the same time to make them work and think they thereby earn them. A great part of the work Overseers of the Poor consists of the investigation of settlements; by this means a certain amount of money is refunded from the township whence the pauper came.

Dr. Taylor said in a few instances he had sent patients to the Overseers of the Poor, and thought it had a stimulating action, effecting the patient to do something for himself. He did not like to attend non-paying patients who live at a distance, neither did he think it right to send such patients for care to other physicians, although he knew instances where such cases paid something to the other doctor.

Dr. Clarke said when he came across long, tedious cases that required much care and medicine he usually referred them to the city physician. With poor patients who cannot pay, he is in the habit of making them do service of some kind in exchange for his advice, and thinks in many instances it has a good effect. Certain cases are too lazy to work. In Boston, certain institutions are in the habit of making applicants for meals work—sawing a quantity of wood, in compensation for the food given them. Some men will work hard and others prefer to go without a meal rather than work and earn it. He thought a similar line of action to this might be taken in Cambridge, and is of the opinion that most of the foreigners imported here are of an industrious nature and not inclined toward pauperism. The

West is largely built up of this class of people. The greater number of paupers are American born, and they form the worst class. Most foreigners come over here with higher motives than pauperism; they come to better their condition, and many instances might be quoted where they become prominent citizens, such as one he had encountered this summer at Chicago.

Dr. Norris differed from this latter view; he thought "the microbes were imported," and that paupers originated, at least, from the foreign element.

Dr. H. P. Walcott said his relations with the Government did not give him the intimate knowledge of the poor which Dr. Bryant possessed. He thought Dr. Clarke's statement worth consideration; it is certainly true that the worst class of paupers are those educated in pauperism, and that we have educated many of our citizens in this respect. We do not import many paupers now because our ports are guarded against the landing of this class, and a large number who come over are recognized as paupers and sent back. State and municipal aid are unfortunate for the poor, as such aid tends to make paupers of them.

DR. VAUGHN: Municipal and State charity is an irremediable evil. Brooklyn has cut off all outside aid; the burden is carried by voluntary organization. Public relief is not charity; it is compulsory to meet an evil that can not be helped. The taxpayer supports it. The associated charities and Overseers of the Poor work so closely together that the latter turn all cases over to the former for investigation. With more or less help from organizations to substitute the work of the Overseers of the Poor, he thought the public would be relieved of much of its pauperism; and he hoped the time would come when by the combined effort of the associated charities and other similar associations, the work would be entirely removed from the Overseers of the Poor.

It is now arranged so that a person can have his or her name erased from the books of the Overseer of the Poor, by paying back such sums as have been given.

Dr. Dow rarely sends a patient to the city physician; he explains that it makes paupers of them and usually they wish to avoid this condition, preferring to pay him something for his service. He questions the wisdom of sending a visitor to the poor, because they are received as a distinguished visitor and not as a friend. The associated charities makes the poor reform without giving them much.

Dr. Lloyd thought the consideration of the poor at this meeting is in their relation to sickness, a complication of pauperism, and a very proper subject to be brought before the medical profession. The pauper is a person in a chronic condition of mental and physical weakness, and requires to be carefully studied, like crime or other diseases. The sick poor must suffer until means are found to obviate the condition of pauperism. This is an evil of civilization, and increases in ratio to the wealth and intelligence of the people. The condition may have come from the mental state of antecedents which have been introduced into this country, but not found among the earlier settlers. This foreign element diseased with crime, immorality, etc., give issue that are dealt with as American born citizens, live in and infect cities, cause crime, poverty and pauperism. All good citizens should act in conjunction to prevent the imposition of these people. The best way of dealing with this class is to make each individual believe he must be self-supporting; the poor man must be taught that he can and must do something for a living unless physically diseased.

DR. Mahechnie thought it did harm to help poor families; we are guilty of doing them an injustice when we do not make them pay their debts. There are few paupers in West Somerville, because the physicians there render such aid as is required of them.

Dr. Henry O. Marcy considered intemperance a great cause of poverty. He asked if the hard times had not increased the work of the overseers of the poor among the worthy poor. There are many Italians of the North end, Boston, who have less comfort than cattle. "He considered "educated men expensive animals."

Dr. C. C. Foster thought that children's homes contributed to the list of paupers, because the children were not taught how to work and earn a living.

Dr. Morril Wyman asked if children that had been placed in the almshouse had any desire to return home?

DR. FOSTER.—No; they want to stay, and while there they hear the talk of the older paupers, which is vile and perfectly horrible for the ears of children.

Dr. Bryant in closing the discussion said that children in the almshouse were associated with old women and bummers; do not get the care or instruction which they should, become and remain paupers. The education of these poor children should be looked after. He considers the medical profession should be responsile for the well-being and morals of all homes into which it is brought.

A district nurse is of great value, to instruct and make homes brighter and cleaner.

Seventy five per cent. of paupers are of Irish descent; next come the Western Islanders and Portuguese. Poverty comes from intemperance and intemperance often comes from poverty; the poor wish to drown their care and sorrow in drink.—*Jour. Amer. Med. Ass.*

## THE PROVINCE OF EXPERT TESTIMONY.

A clear exposition of the province of expert testimony is made by the Supreme Court of Jersey in Koccis v. State, just reported. In this case, attempt was made to prove that a foreigner who spoke broken English words of the same purport and meaning. This, it was held, was not a subject for expert testimony. The testimony offered, if admitted at all, the court said, would be received not as an expert's opinion, but because it came within that class of cases in which a witness may state the inference drawn by him from facts within ordinary knowledge occuring in his presence.

Familiar instances in which testimony of this kind may be given, the court says, are: whether two people were in love; whether a man was sick, or dazed, or despondent, or drunk; whether a dog was savage, or a horse gentle,—and, in general, any matter touching physical or mental manifestation or appearance, as well as all questions of identity, resemblance, duration, distance, dimension, velocity, noises, smells and many other matters where the inference drawn by an observer is commonly recognized and received as an equivalent for the congeries of facts that produce it. But testimony of this class, however, so far from being related to expert proof, rests upon diametrically opposite grounds.

The expert witness is one whose possession of special knowledge renders his opinion admissible upon a state of fact within his specialty, without regard to the manner in which the facts are established, and without requiring that they should have come, in whole or in part, under the personal observation of the witness; whereas, the sole ground upon which a witness may give an opinion as to the matters of ordinary knowledge is that they not only came within his personal observation, but that they come into proof so blended with the opinion to which they give rise that it is receivable in proof as a substitute for a specification of the host of circumstances that called it forth.

A failure to observe this distinction results, at times, in the offer of an ordinary witness to give an opinion calling for special knowledge, merely because he has had actual observation of the facts, and at other times in the offer to prove an opinion upon a matter of ordinary knowledge arising from assumed facts, by a witness who has not himself observed them, upon the ground that he is expert upon the special subject. In either of these classes of cases the proof must be rejected; the rule being that mere opportunity will not change an ordinary observer into an expert, and that special skill will not entitle a witness to give an expert opinion when the subject is one where the opinion of an ordinary observer is admissable, or where the jury is capable of forming its own conclusion from facts susceptible of proof in common form.—*Jour. Amer. Med. Assoc.*

SHE—"What do you really think of me?"

HE (with sudden enthusiasm)—"What do I think of you? I think you are the sweetest girl I ever loved."—*Ind. Journal.*

## ATAVISM INVOLVING THREE GENERATIONS.

Dr. Deane, of San Francisco, offers an instructive and interesting object-lesson occurring in my own experience of a family which I have had under observation for nearly twenty years.

In 1849, a young man and young woman were married in the Atlantic States; husband, sea-captain of good old stock, a man mentally above the average, with some literary requirements; a drinker, and I believe syphilitic; died a paralytic in 1876. Wife of good family, also, *petite*, negative disposition, moral qualities not highly developed, refined, still alive. To this man and this woman were born, from 1850 to 1868, eight children, four boys and four girls. Let us follow the lives of these children, beginning with the boys. The first born—a man now in the forties—has always been a good-for-nothing, a drunkard, associating with a class far beneath him, mentally and physically below normal; has never married. Second boy lost at sea. Third boy mentally and physically below normal, died of phthisis a few years ago. Fourth boy, mentally and physically the same as his brothers, appears to be developing phthisis, committed a murder a few years ago, and got off on the plea of self-defense, through influence brought to bear on the authorities. Married a woman far beneath him socially, has two children, oldest with dolichocephalic head and very delicate; the youngest I have not seen. Altogether, he is not a citizen that the community need be proud of. So much for the boys.

First girl, a woman about forty, developed early, physically and mentally, sexually at a very early age. Commenced running about at nineteen, French dinners, etc., with all their accompaniments; after several months of this kind of life she accidentally dropped into the hands of a man of the world greatly her senior, who took a fancy to her and saved her from herself, gradually drew her away from her evil associates, developed her mentally, and she promised to go through life a faily respectable woman. In 1881 she married a man in good social position, who gave her a home with many of the luxuries of life, but the hereditary curse followed her, she began to change about two years since, and that appeared to light up again her sexual nature, like the last sputter of a dying candle. She conceived a passion for a young man, a friend of the family, fairly threw herself at him and never let go until she had seduced him—a clear case of nymphomania. There came very near being a tragedy in consequence, the lover not suspecting to this day how near. The only redeeming point in this woman's life is, that God has denied her the power of perpetuating her kind. Perhaps when the menopause has passed she may settle down, although there appears a tendency in her to develop viraginity.

Second girl married early; very delicate; has had three children. First child an idiot; two children living, both below normal physically, with dolichocephalism strongly marked; mother developed during the last few years exophthalmic goitre; had her under treatment for some months and she improved on anti-syphilitics. Third girl died in infancy. Fourth girl is now about twenty-four and is physically the superior of any of the other children; there was a period of eight years between her birth and the last of the others; she is tall and well formed. How this girl will develop remains to be seen; mentally she has yet shown but little, but I think I begin to see some progress, and I should not be surprised if, perhaps, she was to redeem the family. An aunt of these children was insane. Dr. James Weir says, in an article of the *Medical Record*, "the phenomenon of atavism is more apt to occur in feeble types than in strong, healthy and well developed types." Here we have three generations to examine, each one apparently worse than the last; however, there is a law of compensation which luckily carries off these types early in life, and which seems to deny them the same prolific power of reproduction the healthy and well developed types attain to.

Certainly these people are hardly responsible for their acts any more than the hereditary drunkard. It is a disease, and they should be surrounded by influences from their youth which might counteract the unfortunate results to follow, not only to themselves but to those about them. Above all should our sons and daughters inquire carefully about the antecedents of families before becoming members thereof.—*Pacific Med. Jour.*

# SOCIETY REPORTS.

## SECTION ON ORTHOPÆDIC SURGERYOF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

(*Meeting December 15th, 1893.*)

The discussion of the subject "Torticollis" was opened by a paper entitled

SPASMODIC TORTICOLLIS AND ITS MEDICAL RELATIONS,

By Dr. F. X. Dercum (see page 39), followed by a paper by Dr. Wharton Sinkler on

THE TREATMENT OF SPASMODIC TORTICOLLIS BY CONIUM. (See page 46).

Dr. H. Augustus Wilson exhibited a patient, aged five years. Two years and four months ago, patient is said to have had quinzy. Mother says the child suffered continuously for four months, which appears to cast a doubt upon the correctness of the diagnosis.

The following history was obtained from the mother: At the very beginning of her complaining of sore throat, her neck was stiff so that she could not move it in any direction. There was decided pain throughout chest and arms. Her sleep was disturbed. Upon arising in the morning, it was necessary for the patient to support both sides of her head with her hands on account of severe pain. This condition lasted for four months. Four months after she first noticed the crooked head, the patient came under observation at the Jefferson Hospital.

The diagnosis of caries of the upper cervical vertebræ was arrived at, four months after the first appearance of wry-neck, by the presence of a most marked muscular rigidity around the neck. The muscles in the upright position were tense and yielded only upon the patient being placed in a recumbent position, or when the head was well supported by the surgeon. The sterno-cleido muscles were in a state of relaxation when the patient was recumbent.

A brace was applied, which not only supported the head but maintained immobility and afforded protection, which she wore continuously until one month ago when it was removed. During the last two months of the use of the brace, it was modified so as to permit beginning motion of the head, but restrained the tendency of the head to turn to the right side.

At this time the following observations were made: Head turned to the right,—1½ inches from symphysis of lower jaw to line of mid-sternum. Flexion and extension not easily performed; rotation of head easily to right side, but motion to left impaired by right sterno-cleido-mastoid. When the head was so turned without effort on the patient's part, there was but slight over-action of the right sterno-cleido-mastoid. When the head is thrown backward, both sterno-cleido-mastoids appear alike, and the same obtains when the head is bent forward on the chest. Left shoulder carried a little higher than right. There is a slight lateral curvature principally noticable in dorsal region.

No movements are apparent in second, third, fourth, and fifth cervical vertebræ, which are less prominent than normal, while the sixth and seventh and the dorsal vertebræ move freely. The brace was adjusted towards the last so as to allow a little freedom of movement before it was taken off—about three months time was permitted from the time it was rigid to its removal.

Since the discontinuance of the brace, light gymnastic movements have been permitted, in order to develop the muscles that had become atrophied from disuse while the brace was applied rigidly. Since the head apparatus was made moveable, the patient has noticed a crepitus which was only of periodical occurrence and is now very much less marked than formerly, and appeared to be of the nature of fibrous adhesions.

DISCUSSION.

DR. J. K. MITCHELL: I have very little to say this evening, but should like to report two cases of spasmodic torticollis which present features somewhat different in character from the condition as it usually appears in children, although they were both in young people. My experience has been that this condition is more common in adults, and in them it is exceedingly obstinate to treatment. In children, the fixed form is more common, and either form is much more amenable to all remedies. Operation is more likely to be effectual in children than in grown persons, and this is true, likewise, as to treatment by mechanical measures. Apparatus alone will sometimes effect a cure, as is well illustrated by the interesting case just shown by Dr. Wilson.

My two cases were both in young people; one a man, about twenty, whom I saw in St. Mary's Hospital. He had refused operation, and had come into the medical ward for treatment. He had been handled in all sorts of ways, with drugs and various mechanical measures, without much benefit; nor at first can I say he improved at all, notwithstanding everything that we could do for him, until finally I gave very large doses of gelsemium, with decided improvement, which, however, was not permanent until ice was applied. I did not try conium, which Dr. Sinkler found so effectual in some of these cases; but an ice-bag was kept upon the neck day and night, extending from the anterior border of the sterno-cleido-mastoid muscle back to the cervical spine, as low down as the origin of the nerve supplying the affected muscles. This was constantly worn, as I say, and by it the man was much relieved, the pain and spasm both diminished very much.

The second case was in a young girl and was undoubtedly of an hysterical character, a number of symptoms pointing, as you will presently see, in that direction. She came of a nervous family, and had persistently overstudied at school, which she was obliged to leave on account of the occurence of a violent headache and a general rundown condition, with the exhibition of uncontrollable fits of temper. Her first complaint was pain on the right side of the nose, which extended into the eye, and for sometime at first was limited to this area. It comes on in paroxysms: with some twitching of the muscles of the face, and after it had lasted a few weeks, extended through the side of the face and neck as far back as the spine. It presently began to be accompanied by spasmodic movements of the sterno-cleido-mastoid and trapezius muscles, with some pain in both face and neck. These spasms occurred ten or twelve times a day, and every treatment entirely failed to relieve her. Massage, electricity, drugs,—nothing had any effect. I put her to bed, and on a milk diet, and for the first two or three weeks she grew better. Then the spasmodic movements began again, and during the succeeding month increased in their extent so that she had many times a day, general convulsions, usually opisthotonic. During the attacks, and sometimes between them, she had double strabismus, complete amblyopia, and pupils rigidly fixed in dilatation. At one time, in an access of despair, I bled her, having seen on one or two occasions bleeding do good in hysterical convulsions. We drew some 18 or 20 ounces, and for a week she was much better. Then she relapsed again, and, finally, when her family was worn out, and two or three nurses had been used up in the service, I took her to the Infirmary for Nervous Diseases, left her there with a strange nurse and under the mostly rigid rules of isolation, and from that day she had no attack of convulsions, the pain rapidly diminished and she is now perfectly well.

The case, as I have said, was of course of an hysterical nature, but at least one distinguished physician who saw it in consultation with me, was of opinion that she had meningitis at the base of the brain and would certainly die

DR. J. K. YOUNG: The subject of Torticollis has been so thoroughly discussed this evening that there remains but the mechanical treatment to be considered. A great many mechanical appliances have been proposed, but most of them are unsatisfactory when applied. Torticollis is divided into two classes—congenital and acquired. Congenital cases are those which depend upon deficiency of the cervical vertebræ, malformation, uterine pressure, and adhesion between the amnion and the skin of the face as suggested by Peterson.

The acquired cases may be traumatic, tetanoid, paralytic, compensatory, cicatricial or idiopathic. It is obvious that in paralytic and tetanoid cases no operation is of service.

The simplest form of apparatus is that used by Dr. Ashhurst, and as originally suggested by Little. It consists of a piece of adhesive plaster about the head, another one about the upper part of the thorax, and a firm muslin roller bandage from the chest region on the side opposite the chest and front. After operation the head may be placed in the correct position by means of a plaster-of-Paris bandage. The bandage which I prefer, in all operations upon the head and neck, is the starch bandage, which may be strengthened by strips of a wood bandage and strips of aluminum.

Another form of apparatus is the Minerva collar pattern, which may be made of felt, leather or other material.

The apparatus of Barwell, referred to under the title of "A cheap and simple apparatus for the treatment of torticollis and cervical caries" is the butterfly pattern. It may be made of felt, cut in shape and adapted to the head and neck.

Of the more elaborate forms are those on the principle of Jorg. Of this pattern there are several; the best one is that used by Dr. Schaffer of New York. It consists of an apparatus applied to the back, from which is erected a head piece and a chin rest, and which is attached by a universal joint which admits of its being placed in position. Sayres' apparatus is made upon the same principle.

Dr. Davis' appliance consists of a broad piece of stiff material fitted to the back, with a peculiar shaped head piece which is attached by means of a screw. Other good examples of this appliance are found in St. Germaine's work, page 239, under the title of Minerv de Bouvier and Ernst, of London.

Extension of the head is now used both abroad and in this country in the mechanical treatment of this condition. For this purpose Hilliard's appliance is more elegant than the ordinary extension head piece, and the one I exhibit, is the apparatus used by Dr. Willard in the treatment of cervical caries. When used for torticollis it must be longer upon one side so as to make more pull upon the affected muscles.

To render the subject more complete I should perhaps refer to the method of DeLore of the forcible correction of posterior wryneck. The patient under ether, is placed on the edge of the bed and forcible correction of the deformity is made. In cases where this operation is employed it is necessary to positively exclude cervical caries. I had related to me by a country practitioner, a case in which fatal results occurred in attempting to perform this operation. I have seen many cases of torticollis follow cold, and in such medical treatment has been effective in a few days. After tenotomy, I strongly urge tne use of massage and gymnastic exercises.

Finally, I wish to refer to a number of cases of torticollis occulaire, which I have seen in the past two years. These are due to some loss of equilibrium of the ocular muscles, and they are usually corrected by the application of the proper prisms, the superior or inferior rectus being the muscle usually affected.

When torticollis is due to cervical caries, as it sometimes is, manipulation may produce serious results.

I think I can reply to the question of Dr. Wharton's in regard to the occurrence of mastoid tumor. There are two varieties of cases; in one there is a simple hæmatoma, in the other, rupture of the fibres of the muscle. In the latter variety of cases torticollis occurs. Previous to Whitman's paper, all statements upon this subject were without foundation in fact, and were simply quotations from the writings of Pieffen Bach.

DR. H. R. WHARTON: I agree with Dr. Willard in believing that good results follow operation in cases of fixed wry-neck. I have had some experience in the treatment of wry-neck, both in children and in adults, and I have seen marked benefit result from simple division of the sterno-cleido-mastoid-muscle.

Dr. Dercum mentions asymmetry of the face in connection with this disorder. I saw this well illustrated in a boy, recently under my care at the Children's Hospital, in whom there was asymmetry of the face and skull. I think the want of success in a good many operations is due to the fact that many of them are left without after treatment by apparatus, gymnastics, muscle stretching, etc. If this is not done relapse is sure to follow. In my opinion it is as important as the operation itself.

I should like to ask whether any of the gentlemen present have ever had any experience with wry-neck following congenital mastoid tumor. These tumors are often due to the rupture of some of the fibres of the mastoid in labor and we might therefore look for wry-neck in connection with this accident. A few of the cases I have seen of such tumors have not been followed by the development of wry-neck.

DR. BENJ. LEE: I came here this evening expecting to be simply a hearer and to be instructed, and I need hardly say that in reference to the latter expectation I have not been disappointed. Both the papers and the discussions have been of deep interest. The only point which occurs to me to refer to, is Dr. Wilson's case, concerning which I think we may say that we accept his diagnoses without hesitation. It recalls to me a case which I saw early in my practice, some twenty-five years ago. It was a very marked case of wry-neck in a child about four years of age. On my first examination I pronounced it to depend upon cervical caries. I applied suspension by means of a rachet apparatus attached to the child's high chair, and in a few days marked improvement resulted. Suspension was kept up constantly during the day; she was never allowed to sit up except when the head was supported. In the course of a few weeks, I applied a brace with a head support. The wry-neck entirely disappearrd and the case eventually recovered.

This leads me to say that I believe that in every case of wry-neck in a child, we should examine carefully to see whether there is not caries present. I believe the former is frequently an early symptom, and that long before any deformity of the bones can be detected, we may find wry-neck, resulting from pressure on the nerves at the point of emergence, or from inflammatory irritation of the cord.

The attempt to overcome the muscular contraction in either spasmodic or spastic torticollis, by the sheer force of mechanical appliances, I believe to be very rarely successful. In this connection I would say however, that in many cases I have had good results from suspension, carried on systematically and persistently, and have attributed the improvement to diminished irritation of the nerve trunks. Contracted muscles, I think almost invariably depend upon a central irritation existing at least as far back as the point of emergence of the same from the vertebral column. Dr. Mitchell's case is very instructive and, to me, very interesting. I have been accustomed in all such cases to look for a centre of irritation in the pelvic region reflected to the upper portion of the cord. A rectal or vaginal examination will often reveal a source of irritation of some form either rectal, uterine or ovarian, in the pelvis. If this is relieved, we shall occasionally find to our great surprise and delight, a diminution of the central irritation with complete relief of the reflex affection.

DR. F. X. DERCUM: I do not deprecate tenotomy in fixed wry-neck; in spasmodic torticollis, however, it is certainly little more than a makeshift expedient. In regard to the tumor noted in the sterno-mastoid muscle in infants at birth, it is sometimes due to hæmatoma, sometimes to tear and inflammation of the muscles. When tears occur, fixed wry-neck is very apt to ensue. I think that we ought to be more careful in speaking of our results; cases of spasmodic torticollis are often reported as cured when they are only relieved. Very often indeed, we find a case recorded as cured and find that the account ends by stating, "In six months a slight return of the spasm occured," or "A slight movement of the head only could be observed," and other expressions of like purport. Certainly while drugs, such as gelsemium, conium, and various surgical measures give marked relief, they generally fail to cure absolutely.

DR. J. HENDRIE LLOYD: In discussing the pathology of wry-neck it seems to me that it might be wise to pay more attention to the condition of the muscles; I know it is not the fashion to look for the possibility of this disease in the muscles either in the fibre or in the sheath. I have no scientific data upon which to found a statement that wry-neck is a myopathy, but it seems to me to be reasonable from the fact that this disease is not associated with any particular nerve trunk, but is distributed through irregular muscle groups.

It is popular to attribute all muscular involvement to central disease, which necessarily eliminates myopathia. I do not myself believe that we are on sufficiently firm ground to positively assert that all these troubles are located in some form of meningitis, or irritation of the nerve centres. In

recent years it has been found necessary to remove several diseases from the groups of central disease and to place them among the myopathies. This may yet have to be done with wry-neck.

I was much interested in Dr. Mitchell's case because it exhibits a not unusual form of hysteria. Hysterical torticollis has been described by French authors. It is simply one of the varieties of hysterical contracture. In his case the convulsive phenomena, the contracture, the fact that the patient was cured by isolation, are all very characteristic of hysteria.

DR. DEFOREST WILLARD: Dr. Dercum has spoken of the unsatisfactory results of myotomy of the sterno-cleido-mastoid muscle. While I grant that in a considerable number of cases myotomy does fail, yet in many instances it does give permanent relief. I have seen cases in which there has been no return of the spasm for fifteen or twenty years and this may be called permanent cure. There are a certain number of spastic cases which cannot be relieved by this operation, but in inflammatory troubles excellent results can be obtained from myotomy. I advise first, medical treatment; if it fails, then mechanical measures and myotomy; then neurotomy.

In regard to the question of subcutaneous or open section. At the present time we are much more inclined to the open method since there is less fear of sepsis than formerly. In a female, however, a large scar is annoying and in girls I perform subcutaneous tenotomy when it can be done with absolute safety. I make the puncture with a small oculist's knife so as to avoid the entrance of air even, should a vein be wounded.

In many cases if the sterno-cleido-mastoid is firmly stretched, and if a very blunt tenotome is carried along the posterior face of the muscle, there will be no injury to the vein and the muscle can be entirely severed without danger to other structures. If such division is not sufficient, the mastoid insertion is also divided, and abundant correction is secured. Gymnastics and muscle stretching should be practiced for a long time.

I recently saw a patient, a young girl upon whom I operated three years ago; her neck was in absolute straight position, and it was very difficult to decide on which side the operation had been performed. She had had continued gymnastics.

I have never seen the pleura injured except in one case. It was in a case of Dr. Agnew's, and the patient died from septic pleurisy. I believe that is the only case in this city where death has occurred from such cause.

I think that we ought to insist upon gymnastics being carried on after myotomy. Without it there is little use of tenotomy or nerve stretching.

When medicines, hypodermics, electricity, myotomy fail, I think it far better to excise a considerable piece of the nerve. It is better to attack the spinal accessory nerve high up before it reaches the sterno-mastoid, as then there is no reunion.

Dr. Rhein recently collected for me forty cases of neurectomy and nerve stretching on record, and his figures give eighty per cent. of cases which have remained cured. There was but one death, and that from erysipelas. Thorough excision is an operation justifiable in these cases of spasmodic contraction.

In rotary cases, division of the spinal nerves is, of course, the only operation which promises much hope. Simple division of the spinal acessory would not be of much service, but I do not think excision of all the nerves should be attemped until all other means have been exhausted.

If we are positive that spinal caries exists forcible reduction should be excluded.

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### The Treatment of Pneumonia in St. Francis Hospital.

Dr. Arnot Spence, states that after an experience with two hundred and twenty-eight cases the writer can recommend the following plan of treatment. In the first place, the bowels should be freely moved with five grains of calomel, well rubbed up with milk and sugar, or if the patient is too weak a more gentle laxative may be employed. A half-ounce of the following prescription may then be given every two hours:

℞ Tr. aconiti..... mxxiv.
Tr. opii camphoratae..... ʒij.
Liq. ammonii acetatis.
Syr. zingiberis..... āā ʒss.
Aquae, q. s. ad..... ʒvj.—M.

Sig. Half-ounce every two hours.

The aconite is given primarily for its effect on the heart and blood-vessels, and thus on the inflamed lung, and secondarily to reduce the temperature. It produces a quieting and slowing of the irritable and rapid heart, and a reduction of the arterial pressure, thereby lessening the amount of blood in the congested lung. It controls the temperature within a safe range, and prevents the marked exacerbations so common in typical cases of this disease. In strong and full-blooded patients, veratrum viride may be substituted for the aconite in this mixture, and used in about the same dose. The paregoric is added to ease the short and harassing cough, which is often such a disturber of rest. The spirit of mindererus acts as a diaphoretic, keeping the skin moist, and in its way relieving the kidneys to some extent. Besides assisting thus to keep the temperature down, it is also a stimulant.

Throughout the administration of this mixture the heart was most carefully watched to note the effects of the drugs, and, all things being favorable, it was continued until the fall in temperature denoted the crisis of the disease. When further stimulation seemed necessary, whiskey was freely given, but never unless it was indicated. The administration of alcoholic stimulants all through this disease, as is frequently done, is a practice capable of doing great harm.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES for January. Dr. Maurice H. Richardson, contributes an interesting paper on

**Appendicitis,**

based on a personal experience of one hundred and eighty-one cases. He calls attention to the fact that the deaths from appendicitis are greater than one would suppose because, undoubtedly, many cases are diagnosed as typhoid fever or kindred diseases. The author says that the diagnosis is not always easy, and that it is often difficult to distinguish between this disease and certain others, though the history, with the local signs, is sufficient to make a diagnosis in the majority of instances. With very rare exceptions, a diseased appendix is the cause of all peritonitis, local or general, occurring in males. He says that not infrequently he has found a gangrenous appendix in cases where a diagnosis of internal strangulation had been made by the most experienced men. In all cases of general infection in which the lesion is obscure, the possibility of an appendicitis must be borne in mind.

Pain considered alone very frequently has no direct relation with the usual anatomical seat of the appendix. In making a diagnosis, therefore, the seat of the pain in the first hours of an appendicitis is of no great importance. Tenderness is a more important symptom for diagnosis than pain, inasmuch as this symptom is usually placed directly over the lesion.

The existence of vomiting of stercoraceous material, or of matter of a coffee color, he regards as a very serious symptom. The septic nature of the vomitus must also be taken into account where anæsthesia is used, because in several instances a fatal pneumonia has followed, or a septic bronchitis has complicated an otherwise favorable course.

In regard to the state of the bowels, he states that a large number of cases are accompanied in the first hours of the attack by more or less diarrhœa. In some the diarrhœa preceeds the attack.

As to the time of perforation, he states, most unequivocally, his conviction that in all severe cases of appendicitis, there is a larger or smaller perforation, with extravasation. The first symptoms in severe cases of appendicitis depend upon a perforation, and not on a catarrhal or an ulcerated process in the interior of the appendix. In all cases of severe acute appendicitis, with localized peritonitis, seen immediately, or within a few hours, he believes that perforation already exists, and there is no question of waiting for perforation to take place on the third, fourth, fifth or any other day.

The state of pulse throws little light on the diagnosis, but is valuable for prognosis. In his experience a pulse of 120 in an adult is a grave symptom as to prognosis, depending, as it does, upon a serious constitutional infection. Its value, however, varies with the extent of the general peritoneal infection.

The temperature in this as in other forms of peritonitis has very little weight both as to diagnosis and prognosis. He has discarded the temperature almost entirely as a guide to prognosis. It is an aid to diagnosis, however; but too much stress must not be laid upon it. A very rapid respiration is always a grave symptom, unless it depends upon merely mechanical distention. Caused by septic absorption its existence is of the gravest import. In a certain percentage of cases it is due to some complication in the lungs.

Where distention exists, the abdomen should be carefully auscultated for evidence of intestinal action; for even in some cases of the greatest distention there is no paralysis of peristalsis. The existence of distention dependent upon a local infection is of the gravest import. Whether due to portal thrombosis or to local infection, with simple paralysis of peristalsis, no system is of more importance in the diagnosis and prognosis of the disease than a distended abdomen, accompanied by vomiting. Death almost always follows. The existence of sounds of intestinal action are not only reassuring but call for the exhibition of cathartics and the rectal tube.

Examination of the rectum should never be omitted in suspected cases. In those cases in which the diseased appendix hangs over the brim of the pelvis we almost always get rectal tenderness.

The author states that with one exception there has been marked leucocytosis in all the cases of perforation that have come under his care.

In regard to the treatment, the author believes that all cases of circumscribed abscess should be drained. The adhesions should not be broken between the abscess and the general peritoneal cavity. In a localized peritonitis of appendicular origin, where there is an adhesion to the abdominal wall, the incision should be made through the most prominent part of the tumor When the pus is reached, the abscess cavity should be drained by means of rubber tubing and gauze. If the cavity is very large and extends into the flank, flank drainage should also be used. The author thinks that drainage among the healthy intestines adds to the gravity of the case and for that reason is opposed to the tearing through of adhesions in cases of circumscribed abscess. Where it is possible to evacuate such cavities through the vagina the author believes that this is the best method to use. Nevertheless, drainage through the vagina and rectum is very unsatisfactory, and the author would not resort to this method unless the abscess was pointing unmistakably downward.

In the vast majority of cases the abdominal route must be selected on account of the abscess being unattached to the abdominal wall. Here every precaution must be taken to avoid contaminating the peritoneal cavity. The intestines should be protected by means of gauze and for this purpose the author prefers gauze sterilized by heat. Iodoform gauze he rejects on account of the dangers of absorption. In cases of localized peritonitis with probable general infection the adhesions about the appendix should be freed and the intestines thoroughly irrigated or wiped and every dependent portion carefully drained. Such cases should be operated on at the earliest possible moments, the earlier the better, just as soon as the gravity of the situation is realized.

In relapsing or recurring appendicitis the author believes that the operation should be advised and performed in all cases where, from frequent attacks, we are able to infer that there is chronic trouble. He thinks that it is a good plan to cauterize the base of the appendix before covering it in with peritoneum.

In regard to the use of the salines in appendicitis the author takes the ground that they may be given with safety in the majority of instances of catarrhal appendicitis, in appendicular colics, and even in slight extravasations not only in the outset but throughout the disease. Mild cases he to thinks do not require salines but do just as well on opium. There is always danger that a mild case will become a fulminating one and in the latter condition and in all cases marked by a sudden onset salines or other cathartics should be avoided. On account of the danger of causing extravasation he believes that cathartics should never be used in the beginning of an attack of appendicitis — that the use of opium is far more rational, if anything must be used. After the disease has been going on long enough to cause firm adhesions or after the appendix has been removed, or when, having drained a localized peritonitis, gauze barriers have been placed to prevent extravasation, it is a different matter and cathartics are useful. But up to four or five days the adhesions are not strong and the increased peristalsis may cause extravasation, and rupturing the adhesions produce a fatal peritonitis.

The author urges the importance of a through bacteriological examination and states that the bacillus coli communis has been found in most cases of septic serous effusions into the peritoneum.

In regard to the prognosis, he states that it depends entirely upon the variety. In the mild cases, with one or two exceptions, recovery without operation has taken place. The prognosis in cases of localized peritonitis is almost invariably good. Recovery has been invariable where the operation has been limited to simple evacuation, unless an incipient general peritonitis existed at the time. The prognosis where appendicular abscesses have been opened and drained is good. In case of well-established general peritonitis, where there is a severe constitutional infection, where the intestines are paralyzed by the local poison, the prognosis is invariably hopeless. Where there has been a serious attack of appendicitis, with an extensive localized peritonitis, or in those rare cases where recovery has followed a general peritonitis, a subsequent sudden perforation has been followed in several instances by the most rapidly fatal result.

Out of the 181 cases operated on there were 43 deaths—24.3 per cent. In practically all the fatal cases general peritonitis was the cause of death. One fatal result was due to delay in operating.

Dr. Charles L. Dana contributes a paper on

**The Microbic Origin of Chorea,**

reporting a case with the autopsy. As the results of his investigations the author believes that there is a meningitis of the cortex which extends into and in places involves the cortex. It is characterized by an active connective-tissue proliferation and the presence of diplococci in the meninges and cortex. In the meninges and cortex are small hyaline bodies which indicate a degenerative change of the brain substance. This degenerative change effects the deeper part of the brain to a less extent, extending down to into the capsule and lenticular nucleus, but not the optic thalamus. There is a meningitis with active vascular changes in the upper part of the cord which seems particularly to surround and effect the roots of the nerves as they leave the medulla and cord. The paper is illustrated by woodcuts of the patient and the microscopical appearance of a portion of the brain as well as a colored plate showing the hyaline bodies spoken of in the paper.

Dr. W. W. Keen reports

**Four Cases of Brain Tumor, in Three of Which Operation Was Done—Two Operative Recoveries—Ultimate Death in All.**

In the first case, the situation of the tumor was probably located correctly and trephining afforded a very great relief to most distressing symptoms. In the second, the tumor was almost exactly located, but, from the probable size and position of the tumor, and the condition of the patient, it was decided not to operate—a conclusion justified by the post-mortem. In the third, the position of the tumor was erroneously diagnosed, and an unwise operation was followed by death. In the fourth, the tumor was not recognized at the operation but was found at the suspected site at the post-mortem; the operation, while it could not afford relief, did no harm.

The author lays down the rule that tumors which are inoperable should be meddled with as little as possible. He also calls attention to the value of the amount of bulging of the brain as an indication of the size of the tumor, and which will, therefore, enable the surgeon to some extent to decide on the wisdom of greater or less interference in such cases.

The paper is illustrated by a portrait of one of the patients showing a peculiar bulging of the head after operation, and also the cuts of the brain showing the positions and size of the tumors. The paper will be continued in the next issue.

**Protozoa and Carcinoma.**

is the title of a paper by Dr. I. Adler. The author concludes his paper by saying that the existence of parasitic protozoa in cancer is probable, though the greater part of what has hitherto been described as parasitic is certainly not so. No constant or in any way specific organism has as yet been demonstrated beyond the possibilities of doubt. At present no facts, histological or otherwise, compel the assumption of a parasitic origin of carcinoma, while there are very strong and valid arguments against such assumption. Further study of the subject is urgently needed in the author's opinion.

The remaining papers in this issue are: "On the Neurosis following Enteric Fever known as "The Typhoid Spine," by Dr. William Osler; and "Some unusual New Growths of the Vulva," by Dr. R. W. Taylor.

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THE CANADIAN PRACTITIONER

for December. Dr. B. E. McKenzie contributes a paper on

**Pott's Disease—its Early Diagnosis and Mechanical Treatment.**

He summarizes the teaching of the paper as follows:

(1) Due attention to the following symptoms and signs will generally enable the surgeon to make a diagnosis before the stage of deformity has come:

(*a*) The *clinical history*—noting the *chronicity* of the case.

(*b*) The peculiar *carriage* and *gait* in walking.

(*c*) Pain in the *distribution of the spinal nerves.*

(*d*) *Muscular spasm* in the region affected.

(*e*) Lateral or antero-posterior *curvature, other than that so called angular curvature which marks the later stage of the disease.*

(*f*) The *disposition to recumbency.*

(2) Mechanical treatment, permitting the patient to be out of bed, is preferred in most cases to plans which necessitate recumbency and a life indoors.

(3) The principles embodied in the use of the plaster jacket most fully meet the indications. When necessary to employ a head support, the croquet hoop is one of the best.

(4) Rawhide is a better material to employ than plaster of Paris.

(5) The object sought in immobilizing the spine is primarily to allay irritation and to lessen physiological activity in the part affected; and, secondarily, to prevent unnecessary deformity.

Dr. A. F. McKenzie discusses

**The Nature of Inflammation.**

He concludes that

(1.) It is a local process attended by structural, nutritional and functional changes in the part affected.

(2.) While these changes are locally injurious, and in the case of wounds hinder or prevent the normal healing process, yet they are probably an effort at defence on the part of the organism and the tissues affected.

(3.) While the most frequent essential cause of inflammation is probably a local invasion of pathogenic microbes, yet other causes may produce apparently the same effect.

(4.) Considering the desirability of not making any unnecessary changes in our terminology of disease, it does not appear that our knowledge is at present accurate enough to warrant us in limiting the term inflammation to the result of a local invasion of pathogenic microbes.

(5.) The antiseptic precautions which it is now considered necessary to take, and which, at least, are not apt to do any harm, are within the means and capabilities of ordinary practitioners, and he who is anxious to do the best he can for his patients will not likely neglect them.

Dr. T. K. Holmes reports "Two Cases of Laparotomy for Unusual Conditions." The first operation was performed for an ovarian abscess where the diseased condition was confined to the ovary, the fallopian tube being healthy. In the second case there was complete paralysis of the intestines requiring puncture of the gut to allow of the escape of gas. The patient recovered.

The remaining papers are "Mitral Stenosis," by Dr. G. A. Peters; "Rupture of the Heart," by Dr. J. L. G. McCarthy; and, in the clinical department the report of a case of "Cholecystotomy" with recovery, by Dr. J. W. F. Ross.

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**An Infant with Alcoholic Liver.**

An inquest was lately held by the City of London Coroner on the body of an infant, aged six months, the daughter of a hawker. The mother deposed that she and her husband had tramped from Yarmouth to London, and that a doctor at the first-mentioned town had told witness to give the child some sherry and brandy, and so far as brandy was concerned, she had carried out his instructions. The medical man who made a post-mortem examination of the child deposed that the liver was four times the natural size, and that death was due to pneumonia. A verdict was returned in accordance with the medical evidence. A case of this kind is a forcible reminder that one cannot be too precise in giving directions to the uneducated friends of patients. Most persons familiar with the treatment of children's ailments know the value of brandy in emergencies. No sane practitioner, however, would order the prolonged use of alcoholic stimulants for children of tender age. The error probably lay in the failure of the Yarmouth doctor to impress on the mother that the spirit was to be used as a momentary stimulant only. —*Med. Press and Circular.*

# PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

## MEDICINE

### Treatment of Disease of the Appendix Vermiformis and its Results.

Drs. J O. Affleck and John Duncan recently read papers on disease of the appendix before the Edinburgh Medico-Chirurgical Society. Dr. Affleck said that within the last fifteen years it has been proven that the vast majority of cases of what was designated typhlitis and perityphlitis are due to lesions of the appendix. Inflammation of its substance is the disease to which it is specially liable. It would seem that the appendix may simply be enlarged and inflamed as the result of a catarrhal process, either extending from the cæcum, or set up by the presence of an irritating concretion. The changes in the appendix may be of more serious character, in the form of adhesions, torsions, suppurations, ulceration, perforation, and even gangrene. In such instances there is not only localized peritonitis, but not infrequently a collection of pus. He suggests that its peculiar vulnerability may be due to its being an unused structure, and consequently to its lacking the natural vitality of the rest of the alimentary canal. Dr. Duncan observed that we meet with three distinct varieties of the disease, the diffused, the localized, and the relapsing. In the first variety, the moment it is ascertained that the peritonitis is purulent, laparotomy must be performed. In the second variety, the guide to operation is the presence of pus. In the third, or relapsing variety, if the determination to operate be arrived at, it is well to do so in an interval of quiet, when the inflammatory action is least pronounced. In all cases of the acute variety in which the diagnosis may contain an element of doubt, as well as in all cases where purulent peritonitis is fairly assured, the proper course is to incise, in the first place in the middle line. In operating in that class of cases in which the inflammatory action is localized in the region of the cæcum, the situation of the incision will be determined by the indications of purulent collection, always with a tendency toward the point opposite the anterior superior spine, which experience has shown is most convenient for reaching the appendix.—*Edin. Med. Jour.*

### The Sort of Athletics for the Building of Strong Men.

Athletics have gained a strong hold upon college men (*American Lancet*). In fact, one hears more in the newspapers about Harvard's and Yale's athletic clubs than about their bright scholars. Many other colleges have won a certain notoriety by the success of their athletic clubs. A few years ago the writer knew a boy bright in scholarship, true in his manly instincts, noble in all his conduct. He was fond of athletics, and won distinction in Yale both as a scholar and as an athlete. But shortly after his graduation he was attacked with a fatal disease of the lungs. For his athletic work large lungs were needed, but when he dropped such work the lungs in their degeneration fell an easy prey to disease, and the world lost the services of one of the noblest of spirits. Not long since, on a visit to a college where students indulge in foot-ball, the writer observed that many had effusion into the knee-joint. He was told this was the "foot-ball knee." At least one example was observed in which this disease finally necessitated the amputation of the leg."

"Base-ball fingers" have become quite a common deformity—one which cripples in many ways in most pursuits of life.

No sort of athletics compensates for bodily deformities. Every physician is familiar with cases in which over-development of muscles in the training for certain games has resulted disastrously. Excessively developed muscles may be good for show, but they are not good for healthy life, especially in brain workers. Athletics for competitive feats of strength and endurance are pernicious, illogical, and dangerous (Lydston). It were far better for the average boy or man to be content with perfect control and excellent nutrition of muscles of moderate development. Strong men are not best constructed by the so-called perfect training.

Brain-workers and those who lead sedentary lives are unwise in attempting to become general athletes. That sort of athletics is best which (1) is free from serious danger to life and limb; (2) is natural and pleasing to the individual taking it; (3) promotes a healthful flow of blood through every portion of the body, the more equably the better; (4) is regular as is the hour for meals and sleep; (5) permits cheerful companionship; (6) does not seriously disturb thelordinary duties of life. In short, those ath etics are best for the student which are subordinated to his work as a student and the part he expects to take in after-life. Base-ball, foot-ball, lawn tennis, as friendly games for simple exercise, are well enough, but when entered into "to beat" they sadly lack the features needful to commend them to the thoughtful physician.—*Medical Review.*

### Anæmia of Miners in Children.

A grave form of anæmia is produced by the presence of a worm in the intestine, the Anchylostonum duodenale, first described by Dr. Dubini, of Milan. The author has been able to observe twenty-one cases in children below the age of eleven. Intestinal symptoms are more common than in other

forms of anæmia. The anæmia becomes rapidly worse. The fæces are very variable, often diarrhœic, sometimes streeked with blood; in other cases the stools are normal. The diagnosis is based entirely on the examination of the fæcal material, in which the eggs of the anchylostome are found. These are characteristic, being in segments—mono, bi-, poly-cellular. The eggs of the ascarides lumbricoides often accompany those of the anchylostome. The diseased arising in an infected locality (such as mines, collieries), the presences of other anæmics in the family, especially if among them were miners or men in similiar work, the resistance of the disease to different treatments, point to the diagnosis, and this is determined by the microscopical examination of the fæces. The treatment is by the ethereal extract of male-fern. The dose in children should not exceed four grammes, and should be given in an emulsion of some essence to conceal the disagreeable taste. It is necessary to repeat the treatment several times (four or five) at intervals of two to three days. As a contribution to the pathogeny of this form of anæmia, numerous experiments upon animals were made, which demonstrated very beautifully the anto-intoxication which takes place. After having prepared the toxine of the urine from two patients, after the method of Brieger-Otto, rabbits were inoculated with progressively increasing doses. The animals presented, from the first injections, all the characteristic symptoms of the anæmia in question. Quickly, upon stopping the injections, the animals returned to a state of health. Control experiments with urine of patients after the explusion of the worms, produced no changes in the blood of the rabbits experimented upon.—*Bost. Med. and Surg. Jour.*

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**Frequency of Tuberculosis among Nurslings.**

The examinations of the author (Enguelne) were bacteriological and pathological, as well as clinical. They were made with great thoroughness, but were confined to the institution children of the Hospice des Enfants Assistes at St. Petersburg. These researches gave the following results:

1. Tubercle bacilli were found in fourteen out of one hundred and twenty children, i. e., 11.7 per cent.; bacilli existed in the lungs in ninety-three per cent., in the bronchial ganglia in ninety-three per cent., and in mesenteric ganglia in eighty-six per cent.

2. Thoracic tuberculosis was found alone in seven per cent of the cases, abdominal tuberculosis alone in seven per cent, and both together in ninety-three per cent.

3. The age of children dying of tuberculosis varied from two months and four days to seven months and seven days.

The author also tried to find the relation of tuberculosis to all the autopsies of ten years, as shown by the gross pathology, with the following result:

1. The mortality of tuberculosis varied from 0.82 per cent to 5.18 per cent of the whole number of autopsies, there being a mean of 2.62 per cent for the ten years.

3. Tuberculosis is most often first recognized between two and three months of age.

4. The increase and diminution of the number of cases of pulmonary inflammation, of intestinal catarrh, and of other affections bears a direct relation to the number of autopsies.—*Revue Mensuelle des Maladies de l'Enfance, Vratch*, 1892.

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**Early Symptoms of Rheumatoid Arthritis.**

Mr. C. F. Griffiths contributes a paper on some neural phenomena of rheumatoid arthritis. The following are the phenomena to which he attaches the greatest importance. First, rapidity of pulse. Not in a solitary case, but in numerous instances, he has counted a pulse of 120, 130, 140, and even 160 to the minute; and yet the patient has been in all other respects non-pyrexial, and has not been subjected to any undue excitment, such as having just had a thermal bath, or exercise. Pigmentary cutaneous changes are of two very distinct forms—a diffuse melasmic discoloration, and a dark brown circumscribed spot, something like a mole, but not raised, and darker than the ordinary freckle. The next symptom is cold wet perspiration, notably of the hands, varying in degree from a mere clamminess to a profuse sweating, as if the hands had been dipped in water. This perspiration, however, is often found to be quite local, and it may be seen standing out upon the skin (especially the feet) following a defined course, as though influenced by one of the cutaneous nerves. There is often pain with this kind of perspiration; of a neuralgic character, and sometimes varying sensations of numbness and tingling. Fourthly, there is the true neural phenomenon of pain: not the pain which is associated with the disease-smitten joints, but that pain which occuring long before there is any evidence of arthritic trouble, Mr. Griffiths believes to be due to a perveted innervation of large nerve-plexuses, or a large area of nerve supply. This early pain occurs in the muscles of the thumb and inner side of the wrist, which suggests ulnar affection; ultimately the pain becomes more diffused and cannot be limited to any particular nerve area. This, especially when attended by the other phenomena, may, in most instances, be looked upon as the harbinger of the coming storm. Other neural symptoms are occasionally met with, such as loss of, or rather preverted sensibility of taste, interference with hearing, and severe gastric disturbances or migraine; and all these without any cause to account for them beyond the assumption that there lurks in the system a poison, of the exact nature of which we know little. As regards the respective values of these phenomena in the early diagnosis of chronic rheumatoid arthritis, that is, at a period before any arthritic or even constitutional symptoms have shown themselves, he thinks that the symptom of pain in localized areas is of very great importance and should be placed first; next, the increased

velocity of cardiac action; and then pigmentation. It will be readily assumed that should two or more of these symptoms appear synchronously or nearly so, the doubt would be pretty well turned into an almost absolute certainty.—*The Birmingham Med. Review.*

### Croupous Pneumonia in Children.

Dr. Francis Hawkins in a paper read before the Medical Society of London, based on 226 cases, says: Most cases occur during March, May and July; the fewest in January, August and December. They, occur, as a rule, independent of antecedent disease, and in the great majority the onset could not be attributed to any definate cause. Fifty of the cases occurred under the age of five years, one hundred and twenty between five and ten, and fifty between ten and fourteen. The disease was most frequent at the ages of five and nine respectively.

Connecting his table with a further series of over seven hundred cases compiled by others, he found that the frequency of the affection gradually rose from the fifth to the twentieth year. Its onset was usually sudden and its chief symptoms of invasion were vomiting, cough and pain, while rigors and convulsions were very infrequent, and hæmoptysis extremely rare. An arrangement of symptoms into groups showed that the nervous system was the one most variously affected. The average daily temperature before crisis was 103° and 104° F., and in about one-seventh of the cases, the fever was of the hectic type, though in only three was such associated with pus in the pleural cavity. The sixth was the commonest day of crisis, it being very frequent on the seventh and eight days. In basic pneumonia it was rather later than in apical. A dull tympanitic note was often present before any differentiation was detected in the character of the breath sounds. In one hundred and forty-six cases, the base of the lung was attacked in sixty-nine, the apex in forty-five; in the remainder the seat of the disease was in other parts. The most rapid respiration noted was 68. Typical rusty expectoration was present in seven cases, the youngest being six years old. Pleurisy coexisted in sixteen cases, pus being found in three. Gangrene of the lung occurred once. A soft systolic murmur was detected as arising during the course of the disease in six cases. Pericarditis was noted in one case, the patient having had rheumatic fever previously. Albuminuria was discovered during the disease in seven cases, and herpes in thirty-six, being in one case on the wrist as well as the angle of the mouth. Delirium was more frequent during the course of the disease than at the onset, and more in apical than basic cases. In the treatment, ice should be used with great caution when the pneumonia was on the left side, as the heart might become slowed and dangerous symptoms arise. As to alcohol, discretion was required to select the cases in which it was needed.—*Brit. Med. Jour.*

## ARMY AND NAVY.

U. S. ARMY, FROM DECEMBER 31, 1893, TO JANUARY 6, 1894.

First Lieutenant Edward L. Munson, Assistant Surgeon U. S. A., is relieved from duty at Jefferson Barracks, Missouri, and will report in person to the Commanding Officer, Fort Assinniboine, Montana, for duty at that post.

By direction of the Secretary of War leave of absence for two months, to take effect on or about January 15, 1894, with permission to apply for an extension of one month, is granted Major John D. Hall, Surgeon.

## NEWS AND MISCELLANY.

### Excursions to the National Capitol.

The Royal Blue Line has arranged a series of personally conducted three day tours from New York, Newark, Elizabeth, Trenton and Philadelphia to Washington, under the supervision of Thos. Cook & Son, the famous Tourist Agents. The dates selected are January 25, February 15, March 8, 29, April 19, 26, and May 10 and 17. The rate from New York, Newark and Elizabeth will be $13.00, from Trenton $12.25, and from Philadelphia $11.00, which will include transfers between depot and hotel and first-class hotel accommodations at Washington. The train will leave New York on above dates from station, foot of Liberty Street, 9.00 A. M., leave Newark, C. R. R. of N. J., 8.55 A. M., Elizabeth, Royal Blue Line, 9.31 A. M., Trenton, P. & R., 10.20 A. M., Philadelphia, 12th & Market Streets, 11.26 A. M., and 24th & Chestnut Streets, 11.42 A.M., and will arrive at Washington 3.00 P. M.

The tickets will be valid for the return journey on any Royal Blue Line train within three days, including first day of sale, thus affording tourists an opportunity to visit the public buildings and places of interest in and about the Capitol.

For more detailed information call on or write Thomas Cook & Son, 261, 1225 Broadway, New York, or 828 Chestnut Street, Philadelphia.

THE
# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### ANTISEPTIC OBSTETRICS.

J. S. DUKATE, M. D., Pond Creek Mills, Ind.

The microbe reigns. In truth, its revels
In human woe, now beat the Devil's.
The greatest wonder, fear and dread
That now surrounds the child-birth bed;
Old doctors never dreamed it so,
When waiting on parturient ladies;
And if their getting up was slow,
The microbes didn't get the babies.
Carbolic acid, Listerine,
Were never thought of in those days,
Nor the Bichloride squirt-gun seen,
All primed to inundate the case.
The only exhortation given,
Was keep your bed, but change your linen.

Nearly fifty years in the practice of obstetrics and the management of 2400 cases of labor and after-treatment of the parturient women, in which number are included about all the varieties and complications of labor at full term besides numerous cases of abortion, ought, I think, entitle an experience and observation from a clinical standpoint, to some consideration in the department of obstetric medicine. Uterine, pelvic and peritoneal inflammations have been of a very small percentage following parturition, and that under what is now termed the "old fogy" regime in use before the present antiseptic parturium was in vogue.

It is proper that both sides of any great question should be heard, and all the facts collected, therefore, I offer a few thoughts on antiseptic midwifery as viewed to-day by so many eminent accouchers.

All admit that this is an age of culture and of scientific investigation, and that the medical profession is not behind in pushing onward and upward to the high place it is destined to occupy among the other sciences. But is there not danger in the struggle for pre-eminence among ourselves? Some are traveling so fast that they are found on some high eminence, way beyond the rank and file, watching for the whole army to overtake them. Wrapt up in their own conceptions, with microscope in hand, they stand making mouths at us, ignoring all the learning and clinical observations of the past, discarding *in toto* all etiology of diseases as taught by physiologists and pathologists of the past, and the ever present microbe, with them enters into every avenue of life and every tissue of the body—a specific bacillus for each human malady. *Wonderful Discovery!* In fact, our clothing, beds, carpets, food and drink are swarming with deadly bacteria, ever ready to pounce upon and annihilate us. But the horrid feature of this wonderful discovery is that the parturient woman is the one above all others, whose life is brought into jeopardy. This haunts the medical attendant day and night, and the entire *arcanum* of microbe-destroyers is brought into requisition to save her from an untimely grave. I admit all this savors of great learning; people stare and wonder, and one would think it was only by miracle or direct interposition of Divine Providence that our mothers survived the process of parturition if the present opinions relative to the management of the parturient female are correct.

If true, the larger number of women, especially in private practice, ought and necessarily would be the subjects of septicæmia, or toxic poisoning in some form, because of the absolute impracticability of carrying out the antiseptic precautions. But facts show such is not the case. I

have had patients placed under the most trying ordeal of poverty and filth, minus all the comforts of life, and yet these would do well, and that in the filth of their uterine secretions, no undergarments for a change, the very kind of soil to foster bacteria; yet these same women were soon up and attending to the duties of the housewife, having had no unfavorable symptoms. I acknowledge it makes us old physicians feel quite humble, and sometimes we almost feel that all our past reading and clinical observation is *nil*, when we see the young-fledged M. D. coming around with his weapons of offensive and defensive warfare against the supposed myriads of germs that threaten the citadel with destruction; but we apply the unction of "*vita brevis—arslonga.*"

Not long ago a physician said to me that he held he would be guilty of malpractice if before he made a vaginal examination in labor he failed to disinfect his hands, clean out his nails, and spray his person; yet this same physician has been engaged in an extensive obstetrical practice for thirty years and has not until recently paid any attention to antiseptic treatment in his midwifery practice. He has been a successful physician in this department to my certain knowledge, very few of his cases having been attacked with parturient inflammations. I requested an explanation for such a singular statement, and his reply was: "You had better be out of the profession than out of fashion." And he "did not propose to remain behind the practice of the day."

I believe the practice of the past for safety and a speedy convalescence from all forms of labor will compare favorably with the present notions and observances. If all is true that is claimed for the present practice, hundreds must necessarily be exposed from the absolute impossibility, under the circumstances, of methodically carrying out the practice. But then we have in cleanliness, soft water and good soap, with good ventilation, I opine, what will meet all the exigencies in about all the cases of parturition. Such has been my experience. A few years ago I was called in to see and treat the husband of a poor woman who a few days previously had given birth to a child. The season was one of oppressive heat. The stench from her undergarments and bed was intolerable from the decomposition of the lochial discharge, which was in excess, yet this woman had a good recovery. Every man who has been in practice a number of years has seen similar cases. Now according to modern opinions, this woman ought to have fallen a victim to some one of the puerperal maladies; but perhaps the bacteria if they did generate in such favorable soil were not so vicious and bloodthirsty as the bacilli of modern times. I repeat, pure air, good alimentation, water and soap are nature's antiseptics, and are about all any parturient female requires. In purely surgical practice, there is no doubt but antiseptics are of great utility, and are indispensably necessary; but there can be no question but what the same extremes have been reached as has taken place in relation to the best remedy in acute inflammation, when judiciously and scientifically employed, viz., blood letting. Common sense and conservatism in medicine is the safe rule; it is the only rational one. The notion that every ill which befalls the parturient female is produced by a specific microbe, and calls for a routine of an unnecessary and often impracticable line of management, which results more to the enhancement of her medical adviser in the opinion of his patient than it does for her protection and comfort, is more, I opine, a fashion in modern medicine than a reality.

I cannot divorce myself from the opinions of the past in regard to the etiology of diseases, especially those which are characterized by acute inflammation—puerperal peritonitis as an example. That the greatest number of the phlogistic maladies are produced histogenically or autogenically, I think is beyond cavil; the peculiar *materies-morbi* so acting upon the blood as to result in acute inflammation. Then, again, meteorologically considered, the direct or remote effects of cold are all factors in the etiology of disease. Several cases of puerperal fever have come under my observation that could be traced to the direct influence of cold upon the system.

Fearful epidemics of puerperal fever prevailed in Edinburgh in 1793, and in Paris, Vienna and Aberdeen in 1795. These epidemics were written up by such clinicians and pathologists as Lock, Hunter, Clark, Campbell, Tonille, Armstrong, Meekell, Lee, Collins, Furguson, Dance, Bovine, Duges and Gordon and Columbat. These authors, all of whom were actively engaged in the treatment of

this fearful epidemic, both in hospitals and private practice, all speak of and describe a peculiar condition of the atmosphere that unquestionably prevailed and gave rise and continuance to the epidemic.

I think the judicious and unprejudiced physician will not adopt in haste and unreservedly any of the leading doctrines advanced in modern medicine. Looking back over the literature and clinical experiences of the past, he will still see a great deal to admire and embrace in the systems of Brown, of Cullen, of Darwin, of Broussais, and even of the fanciful Hahnemann; although when offered to his acceptance as doctrines of universal application, he may very reasonably refuse his assent.

The advocates of bacteriology endeavor to support the doctrine with the microscope and by culture; by the phenomena of post-mortem examination, and by arguments founded on physiological principles. It is affirmed that bacteria are present in this and that disease, therefore, the bacteria must necessarilly be the factor in the etiology of the disease, and are responsible for all the morbid changes. Now parasite conditions may be the result of previously existing morbid conditions, therefore, the mere presence of any variation from the normal is no proof that this condition was the primary cause of the disease in question, but it is in all probability only the result of pre-existing morbid action. Admitting that such manifestations are as universal as they are asserted to be, is there not much reason to believe that very frequently, at least, this very condition supervened during the course of the disease as a consequence, rather than that pathological conditions having been pre-established, and become the immediate cause of so many febrile and inflammatory diseases. We frequently see inflammation supervene in parts exposed to observation many days after general fever has been fully established, why not then other products devoid of organizable lymph and pus cells—the result of morbid changes going on in the diseased parts, yet not absolutely known to the searching investigation and reasoning powers of the pathologist. The theory is as yet a *vexata questio*.

QUERY—If parturient females are in so great danger, why does it not bring all women alike subject to the baneful influence of this dangerous microbe, or is it alone confined to the civilized and cultured? The Greenlanders mostly do all their common business just before and after their delivery, and a peritoneal inflammation is seldom heard of. Long tells us that the Chippewa women as soon as their child is born go into the water and immerse it saying "Oway saggonosh payshik shomagonith," or "here is a young warrior."

Lempriere says: "Women in Morocco suffer but little inconvenience from child bearing."

"The Shangalla women bring forth children with the utmost ease, and never rest or confine themselves after delivery."

Immediately after delivery of the placenta, all clots should be removed from the vagina, and an agreeable bandage applied; all saturated clothing removed; the room kept well ventilated; a light yet nutritious diet allowed, and perfect rest in the recumbent posture enjoined. Then follows a discharge of a sanguinous fluid from the uterus for a few days, which becomes greenish, and lastly pale, and decreases in quantity, disappearing altogether within a month, and often in a shorter time. This is called the lochial discharge. During this flow it is only necessary that the vagina and external parts be daily washed with tepid milk and water. Constipation should be avoided; and the condition of the lacteal secretion looked after. The above is under all ordinary circumstances about all that is necessary for the medical advisor to do for his patient, and the above strictly enforced will, as a rule of conducts, be all that any woman will require for the successful recovery from parturition.

In conclusion, should this article fall into the hands of the older members of the profession who are competent to judge, it will, if faulty do little harm; but should it fall into the hands of the student of midwifery, it will prove useful or injurious to society, according to the correctness of the principles it contains. When I consider how important the diseases of women are, especially of the parturient woman, and how important the prudent management of labor and the entire puerperal state, I think I comprehend the responsibility which falls on those who presume to practice this art. And I feel that what I have stated as my honest conviction, will be found to agree with the observation and experience of our best teachers and practitioners of obstetrics.

# COMMUNICATIONS.

## SURGICAL SHOCK.*

CHARLES P. NOBLE, M. D.,† PHILADELPHIA.

It is proposed in this communication to briefly consider the nature of surgical shock, and then to take up its treatment in detail. Shock is a condition of the body which is characterized by feebleness and rapidity of action of the heart, by the shallowness and frequency of respiration, by the lowering of the temperature of the body, and by the lessened activity of most of its functions. Intellection, digestion, and the secretion of urine all are more or less in abeyance. It is probable, also, that the processes of assimilation and metabolism are profoundly interfered with. Perspiration is usually free, the body being covered with a cold, clammy sweat. This, however, is due not to the increased activity of the sweat glands, but rather to an arrest of the activity of their cells, so that they simply act as strainers for the watery part of the blood to pass through them.

There can be no question that vitality is at a low ebb when shock exists, but there is some difference of opinion as to the real physiology or pathology involved. It is generally accepted that shock is a manifestion of paresis of the nervous system, its symptoms being due to lessened and irregular innervation. The question as to whether the cerebro-spinal or the sympathetic system is most involved is in dispute, and we do not propose at this time to attempt the elucidation of the question. As a matter of fact, injury of the body in any of its parts can bring about shock. Injury to certain parts of the body are especially liable to produce shock. These parts are the testicle and urethra, in the male, the ovary (in a lessened degree) in the female, and the abdominal viscera. Examples of shock from injury to these structures are common, and familiar to every one of experience. The familiar experiment of temporarily arresting the heart's action of the frog by a blow upon the abdomen is a striking illustration. Leaving aside the disputed points at issue, we wish to consider certain facts because of their very practical bearing upon the therapeutics of surgical shock. Among the most important symptoms of shock is the lessened force and greater frequency of the heart's beat. The activity of the respiratory centre, also, is much lessened. The superficial blood-vessels are contracted, so that the surface of the body is pale and even blanched. The temperature of the body is lowered below the normal. These facts are indisputable, and a recognition of the existence of these conditions forms the basis for rational therapeutics. Heat must be restored to the body; the heart and respiratory centres must be stimulated to do their work; and the superficial blood-vessels must be dilated, so that the circulation may be equalized by affording a channel for the blood which has been retained in the great veins of the abdomen. The practice which I followed for some years to accomplish these results will now be given.

*Treatment of Shock.*—The most important point in the treatment of shock is its prevention. Much can be done by prudent management, either to avoid shock or to lessen its degree. In selecting the date for operation a time should be chosen when the patient is in good condition. Almost always this is possible. It is only in emergency cases, and in patients who are suffering from a disease whose progress is steadily and rapidly downward, that preparatory treatment will not put them in better condition. All patients requiring operation should receive careful study, and every therapeutic indication should be met before operation. Especially should the condition of the emunctories be looked after. The bowels, skin and kidneys should be put in good condition by the use of baths, purgatives (especially broken doses of calomel and salines), and the abundant ingestion of water. The *morale* of the patient should

*Read before the Obstetrical Society of Philadelphia, December 7, 1893.

† Surgeon-in-Chief of the Kensington Hospital for Women

not be neglected, as much can be done, by stimulating the courage of the timid and allaying the fears of the despondent, to make the patient look forward to the operation with courage and without dread. All these matters should be attended to prior to the day of operation. The temperature of the room in which the operation is done should be high, from 75° to 85° F. In such a room the loss of heat from the patient by radiation is much less when the operation is done in a cool room. Loss of heat from the patient can be lessened also by the manner in which she is dressed. It is best that she be well wrapped in blankets, and that as little of the skin surface be exposed to the air as the necessities of the particular operation permit. For the same reason the use of wet towels or gauze about the patient is to be deprecated .Evaporation from such wet material chills the patient. Much can be done also by the proper administration of the anæsthetic. Patients should not be drowned in ether. Enough only should be given to maintain anæsthesia, unless to meet a certain indication, absolute relaxation is required. The prevention of hemorrhage, and the avoidance of rough handling of the patient, especially of the abdominal viscera, are matters of the greatest importance in preventing shock. The careful surgeon gives due attention to each and all of these matters of detail, and no one so much appreciates their importance as he who has to deal constantly with grave operations. This applies especially to the abdominal surgeon, because in many cases, when he begins an operation the life of the patient depends upon its completion. He cannot do a part of it and postpone the rest to another day. In many of the long, tedious operations which he is called upon to do, involving multiple visceral adhesions, the very life of the patient itself depends upon attention to every detail to prevent shock, so that he may have time to complete the operation *secundem artem*.

The active treatment of shock consists in supplying heat to the body which has been lost, in stimulating the heart to better work, in counteracting nervous depression, and in overcoming irregular action, especially on the part of the vasomotor nervous system, until reaction shall occur and the vitality of the patient can be sustained by alimentation. In describing the treatment of shock I shall simply give an account of my own practice in the treatment of this condition.

If during the operation the patient begins to suffer from shock and here is reason to expect that this will increase, especially when the operation is not yet completed, I begin at once actively to treat it. One-fifteenth of a grain of sulphate of strychnia and one-fiftieth of digitalin is given hypodermically, and the dose of strychnia is repeated every fifteen minutes until some improvement is manifested in the pulse, until a fifth of a grain is given. If improvement does not manifest itself promptly, and especially if shock be profound or if the patient has been markedly prostrated before the operation, a hundredth of a grain of atrophia sulphate and two or three minims of a 1 per cent. aqueous solution of nitroglycerine are given hypodermically. In still other cases from three to six grains of citrate of caffein are administered in addition. During this time hot-water bottles have been put about the patient, and if the operation is an abdominal section, at times warm water is poured into the peritoneal cavity. I have also employed hot beef-tea enemas, but, as a rule, an enema is not given, because it interfers with the completion of the operation, which is just as important as any one detail in the treatment of shock if not more so. In fact, it is of the highest importance to complete the operation as rapidly as is consistent with safe work. The same is true of the after-dressing of the patient, who should be put to bed as promptly as is feasible.

The bed should have been warmed by having hot-water bottles in it while the operation was in progress, and in all cases in which shock is a marked feature, the sheets should be removed and the patient placed between warm, dry blankets. At this stage the use of whiskey by enema is of service, and at times it is proper to use whiskey during the operation, especially if shock is not another name for too much ether. The use of whiskey or alcohol in any shape is not good treatment for an overdose of ether. The best way to employ whiskey, as a rule, is to give it by enema with hot beef-tea, about two ounces of whiskey and six ounces of beef-tea. Dry friction with the hand or with a dry cloth, especially to the extremities if they are covered with clammy perspira-

tion, will do much to bring about reaction, and also will lessen radiation from the surface by preventing evaporation of the perspiration. Morphia in small doses, one-eighth of a grain or less, is also useful as a heart stimulant and as a an anodyne, if, when the patient becomes conscious there is marked pain. The morphia not only acts as a stimulant itself, but prevents depression which would result from severe suffering. So much for the immediate treatment of shock. Under ordinary circumstances, when the shock is marked and yet not so profound as to be alarming, within half an hour strychnia can be pushed to a fifth of a grain, atrophia to a fiftieth, caffein to five grains or more, and digitalis to a twenty-fifth of a grain, or what is really better, tincture of digitalis to half a drachm, with the fiftieth of a grain of nitroglycerine.

If the crisis passes and yet the patient remains in a markedly depressed state, the question of treatment for the ensuing twenty-four or forty-eight hours comes up. The use of external heat should be continued until the temperature of the body becomes normal, and even longer should the patient complain of chilliness. But the sheet anchors of safety are strychnia, digitalis and whiskey. In a marked case it is my habit to give the following order: To give hypodermically sulphate of strychnia, one-thirtieth of a grain one hour; tincture of digitalis, fifteen drops, with the one-fiftieth of a grain of nitroglycerine, the next hour; three grains of citrate of caffein the third hour; and an anema of whiskey, two ounces, and beef-tea, six ounces, the fourth hour. This order I have had carried out many times for twenty-four, forty-eight and even seventy-two hours. In the worst of cases, for its temporary effect, cocaine has been employed in addition to the above, also small doses of morphia if much pain and especially if great restlessness were present. It is my experience that most patients will take a fifth of a grain of strychnia in twenty-four hours without manifesting symptoms of strychnism. I have not employed the heroic doses of strychnia described by some writers, such as half a grain within two hours, but in a desperate case, watching it carefully, I should not hesitate to give repeated doses of one-fifteenth of a grain every half hour for a short time until some symptoms of irritation appeared. We certainly have no more reliable exciter of the nervous and muscular systems than strychnia, nor any drug which is more capable of maintaining its effect.

Digitalis is also a very reliable drug in the treatment of shock. It is capable of whipping up the heart to increased work, especially for a few days and until a sustained effect can be secured by alimentation. This is exactly what is required in the treatment of shock. Digitalis has, however, one effect which is undesirable. It causes a contraction of the arterioles, and thus increases arterial pressure, so that while it whips up the heart to do increased work, it also hinders the heart through the increase in arterial pressure; hence, it is wise in the treatment of shock, to combine digitalis with nitro-glycerine, which overcomes this bad effect of digitalis. The combination is much more effective than either drug alone. Caffein is a pure heart stimulant, and can be administered freely without evil consequences. Alcohol used judiciously and in not too large quantities, is one of our most important remedies. In shock following abdominal operations, it is best administered by enema combined with beef-tea, which is itself a stimulant. Later in the case champagne by the mouth is often of service, but it fills only a partial indication and is not to be compared in value with whiskey when this can be ingested and retained.

The management of the diet in the treatment of shock is also important. Immediately after an operation accompanied by much shock, the stomach, as a rule, is not retentive; hence it is wise for a time in no case to administer much aliment of any description by mouth. Some hot black coffee or hot beef-tea is as much as should be given. When the stomach becomes retentive, light, easily assimilable food should be employed, as beef-tea, broth, milk (preferably peptonized), egg-nog, punch, etc. These foods should be administered in small quantities frequently repeated. The question of alimentation in the treatment of shock following abdominal operations offers certain peculiar difficulties. Under ordinary circumstances, when shock is not a special feature, it is the rule to administer no food to the patient, who has had a

cœliotomy, for from thirty-six to forty-eight hours after the operation. Then broths or beef-tea from two drachms to one ounce, or two drachms of milk with one of lime water, are given every half hour, and if retained the quantities are increased and the intervals lengthened, until about the fourth day after operation the patient is put upon liquid diet, the amount being regulated largely by the appetite. But in cases accompanied by marked shock, if the stomach proves retentive, it is wise to begin the administration of milk or beef-tea at the earliest feasible time, the quantity being increased as rapidly as in the judgment of the surgeon the patient is able to digest and to assimilate. In some critical cases lives will be saved by judicious alimentation, which would be lost were the usual rules, applicable in abdominal surgery, followed.

It may be questioned whether the term shock should be applied to conditions which persist for one, two, three or more days. It is customary to consider that shock is of temporary duration, and that it ends either in the prompt death or in the recovery of the patient. But there are cases in which it is difficult to assign a name for the condition of patients, if it be not shock. I refer to those cases in which the patient exhibits marked shock after operation, and in which, although after a time the temperature of the body becomes normal and remains so, yet the patient's vitality remains at a very low ebb, the pulse continues rapid, small and feeble. The cutaneous circulation is not restored, the surface of the body being cool and pale; and where no other symptoms are present, except those of pronounced asthænia. This condition must be called shock, or else inanition or asthænia following shock. The condition persists until it is relieved by alimentation, as the nerve and heart stimulants, strychnia, digitalis and even whiskey, are not curative. I have had patients to die in this condition as long as a week after operation, without having manifested other symptoms than those of pure asthænia, and in which the post-mortem examination showed no cause of death. On the other hand, I have seen patients recover from this condition, improvement becoming manifested upon the third, fourth or fifth day, when it had appeared that death was imminent from failure of the heart and respiratory centres. It is in such cases that judicious alimentation is of the highest importance.

In this class of cases the administration of oxygen gas by inhalation, is at times of service. All the vital functions are at such a low ebb, that any agent which is capable of improving the processes of metabolism is of value. My experience with the use of oxygen for this purpose is limited to one case; which was one of marked shock following an operation for double pus tubes, in a woman reduced to the last extremity by hectic. She went to bed with a pulse of 180, with cool and blue skin, and every other evidence of the profoundest shock. The pulse did not fall below 145 for three days, near the close of which period there was every indication of early death from pure asthænia. The plan of treatment already detailed was followed out in her case, and in addition oxygen gas was administered during one day. It seemed to be of great benefit; at all events, she passed out of the shadow of death and made a good recovery.

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### Higher Medical Education.

"In pursuance of the policy recently announced in the resolution to be presented to the American Medical College Association, the trustees and faculty of Rush College have decided to require four years' attendance at College from students who began the study of medicine this year with a view to graduation in 1898; however, those who have already studied medicine one year or more witht a preceptor so that the four years of study, already acquired will be completed before July, 1897, may graduate after three courses of lectures as heretofore. To encourage proper preliminary study, graduates in Arts and Sciences from high-grade colleges, and graduates in Pharmacy and Dentistry from colleges requiring a proper amount of study, and two full courses of lectures will, until further notice, be allowed to graduate after an attendance on only three courses of lectures."

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ONE HYPOTHESIS.—She.—"Why is it when physicians get sick they never attend to their own cases?"

He.—"I don't know, but I should say it was because they can't charge themselves anything for it."—*Life.*

## OCCLUSION OF THE OS UTERI COMPLICATING LABOR AT TERM; ABDOMINAL PREGNANCY.

P. L. HILLSMAN, M. D. ALBANY, GA.

Mrs. H., aged 29; robust, well developed; married nine years. Began menstruating in her 14th year, and was quite regular until she conceived. Six months prior to conception had some form of uterine disorder, and was under the care of a physician until a short time before she missed her menses.

Gestation progressed without any unusual symptoms to full term labor; pains commenced about 1 A. M., and continued until 7 A. M., when I was called to attend her. On arrival I found the pains frequent and rather of an expulsive character. Digital exploration revealed uterus well descended into pelvic canal, with the ovoid form of a vertex presentation, but no os could be found.

After a more minute examination I detected a point somewhat depressed and more attenuated than the surrounding tissue, and being satisfied that it was the os occluded by adhesive inflammation, I proceeded to operate as follows: An ordinary uterine sound was forced through the most depressed point, this was followed by a uterine dilator, and parts expanded until the index finger could pass. Full dilatation was now gradually accomplished with the fingers, aided by moderate chloroform narcosis, and labor terminated without further assistance at 5 P. M. Child was still born, attributable to tedious and prolonged labor. Patient made an uninterrupted recovery, and has since been perfectly regular in her menses.

*Remarks.* The history of this case goes to show that at the time of conception she had endocervicitis, which resulted in adhesion of the parts, there being no menstrual flow to mechanically expand the os.

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M. J., colored; age 42; married; has given birth to five children—last child four years ago; consulted me April 1, 1892, with a history as follows:—Fifteen months ago missed her menses, symptoms of pregnancy followed. She also thought that she experienced quickening, and made ready for the event of parturition. Having gone several months over her time without any symptoms of labor, she consulted a physician, who informed her that she had uterine fibroid, and that she would in all probability get relief after her courses left her. She was comparatively well at the time and continued her vocation—that of an ordinary hand in the field—until about one month before consulting me, when, owing to feeble health, she was compelled to give up her work. The patient, at the time of her visit, was emaciated; complained of gastric disturbance said that she felt as if her stomach was not large enough to hold sufficient food to satisfy her hunger, and vomiting ensued if a moderate meal was taken. Abdomen enlarged, presenting the appearance, of pregnancy at term. On examination I found the uterus anteverted, and with difficulty passed a curved sound three and one-half inches. The tumor gave some evidence of semi-fluctuation. Case was diagnosed as ovarian cyst, possibly malignant in character, as patient had lost flesh rapidly, and the gastic disorder led me to suspect similar trouble in stomach. Operation urged, but owing to her husband being actively engaged in crop, it was deferred for the time. The patient was placed on a tonic course, and nutritive diet ordered in small quantities and often repeated.

July 1st, patient returned and insisted on the operation; stated that she had gained some strength shortly after first visit; had her menses to come on twice, and was hopeful of recovery, but for the past two weeks had begun to fail again, and vomit to her food. Operation July 4, 1892. Under strict antisepsis, abdominal incision was made from the umbilicus down near to symphysis; walls very attenuated and completely adherent to sac. After freeing adhesions on the left side, about one inch from median line a peculiar pouch was discovered, which was at first very puzzling. On further dissection, however, it was found to be a reflection or folding of the sac on itself. This was caused by a partial absorption of the liquid contents of the sac, and the resilient abdominal muscles caused an overlapping of the flaccid walls. The sac having been freed as far as the incision

would allow, a trocar was introduced and the liquid contents withdrawn. Only about one pint of thick caseous matter passed, the appearance of which rather strengthened my fear of malignancy.

Finding it impossible to bring the mass through this opening, the incision was enlarged through and above the umbilicus about four inches. Further effort was now made to free the sac from its intimate adhesions to the adjoining viscera, which being found impracticable was abandoned. The sac was now incised and to my great relief was found to contain a well preserved child weighing seven pounds. This with its shriveled placenta was readily extracted without any hemorrhage. The free portion of the sac was removed and the edges stitched to the abdominal walls. A drainage tube was placed in the abdominal cavity at the lower point of incision and the sac loosely packed with iodoform gauze. Dressing was completed with a thick wadding of iodoform cotton, covered by gauze and bandage.

The patient rallied well from the operation and began to cry piteously for food. She was allowed one teaspoonful of Wyeth's meat juice every four hours, and small quantities of crushed ice.

July 5th—Temperature 99½° F. Slept well during the night from hypodermic of morphia. Still clamoring for solid food.

July 6th—Temperature 100½°. Allowed milk with lime water, in small quantities, and egg albumin water.

July 7th—10 A. M., found patient in collapsed state, with great pain in the bowels; abdomen much distended with flatus, more particularly over region of stomach. Breath exhaled an odor of decayed eggs. On questioning the attendant, her husband, he acknowledged that he had given her three eggs for supper on the previous night, and other things in proportion. He said he did not think she would ever get up without getting more to eat. A stomach tube was inserted and about half a gallon of offensive matter removed and the organ cleansed with warm water. Dressing was removed and the wound found in good condition; very little discharge having taken place since operation. The patient did not rally from the collapse, and died at 6 P. M. Her body was removed the same night to the country and consequently no autopsy was made.

*Remarks.*—The progress of this case up to the third day, led me to hope for a favorable result, and the unhappy termination should justly be attributed to the pain and distress incident to the heavy meal of eggs, etc. The condition of the wound would exclude septic poisoning as a possible cause of death.

## A VERY UNUSUAL FOREIGN BODY IN THE LARYNX.*

W. H. Newman, M. D.

On December 23rd, I. E., an infant ten months old, was presented at the office with the information that at noon of the 19th, she had swallowed something which "stuck in her throat."

The father was under the impression that the offending body was a part of a hickory nut. The child had no symptoms except a slight difficulty in deglutition—could nurse easily, and was as full of life and playfulness as ever.

Another physician, consulted the day previous, said that he could detect the nut, but could not extract it.

When the child ceased crying, Dr. Clark auscultated the thorax and detected an abnormal whistling sound in the larynx, which was so unusual as to favor nothing but a foreign body. Introducing the finger into the oro-pharynx, and raising the epiglottis, an abnormality was at once felt. After several attempts to loosen the body with the finger, a pair of small dressing forceps were inserted and the body extracted. This was nothing less than an open safety pin. It was evidently astride the rim of the glottis, the pin part projecting into the œsophagus, and the fastener in the larynx. This accountsfors the fact that it passed neither into the trachea nor the stomach, and that it w a not coughed up, the arm of the fastener preventing.

The points of interest in the case are:

1st. The rarity of the accident.

2nd. The paucity of subjective symptoms.

3rd. The difficulty of diagnosis and treatment in a struggling infant.

4th. The value of perseverance in such cases.

* In the practice of E. Clark, M. D., Grinnell, Iowa.

# SUBCUTANEOUS INFUSION OF A NUTRITIVE SALT SOLUTION IN CASES OF REFUSAL OR INABILITY TO TAKE FOOD.*

MILTON D. NORRIS, M. D.†

Although the intra-venous and subcutaneous injection of large quantities of fluid, for the purpose of keeping up the blood pressure, has long been practiced, I believe the idea of administering nutriment by subcutaneous infusion originated with Dr. George H. Rohé and was first used in this hospital.

Ilberg and Lehman in Germany, within the last year, report several cases in which good results followed the hypodermic injection of 600 cubic centimeters of a saline solution in the fasting insane, but these gentlemen used a simple salt solution without any actual nutriment.

In the cases I am about to report, the solution used was composed of twelve to fourteen ounces of sterilized water, to which, after partially cooling, was added the whites of two eggs and thirty grains of common salt. This was filtered through cheese cloth. The resulting liquid had about the appearance and consistency of simple syrup, and would coagulate on being heated. Only the whites of eggs were used, because they do not require any previous digestion, but can be directly assimilated.

An ordinary stomach tube and a medium-sized aspirating needle were the only instruments employed in giving the infusion. No force, except that of gravity, was used, and generally only one puncture of the needle was required. The loose tissue over the gluteal region was always selected as the point of puncture, and the time required to inject the fourteen ounces was never over fifteen minutes. The injection of this large quantity of fluid in such a limited area would, of course, make a considerable swelling; but this would disappear in an hour, and there was not a single case in which any bad effect followed the injection.

The subcutaneous method has the advantage over the intravenous of a gradual absorption of the fluid, and therefore no danger of overwhelming the heart, besides there is no danger of emboli or the admission of air into the veins; and this method can be used by any one with a little care, while the intra-venous can only be used by the skillful.

The first case was M. J. K., male, aged fifty years. Case of chronic mania, who was constantly dirty, noisy and tearing. He had been fed for some time by means of the stomach tube, but became weakened and more emaciated every day. He was given fourteen ounces of the fluid at intervals of four days, and fed on the intervening days. His appearance and condition greatly improved, and on the day after the third infusion he began to eat and has given no trouble since.

Case 2. W. P., male, aged sixty-five years. Case of dementia, suffering from Bright's disease. At time of admission his pulse was sixty-four, and every attempt to swallow was followed by vomiting. All efforts to feed by the mouth were stopped and he was given the infusion every day for four days, at the end of which time there was marked improvement; his pulse being eighty and much stronger. He was then able to retain food on his stomach, but from time to time had attacks of vomiting and after several months again became so weak that the infusion was repeated with good results.

Case 3. T. C., male, aged eighteen years. Case of acute mania. Admitted January 24, 1893, at which time he was constantly swearing, crying or singing, and biting at every one who came near him. He was in a very weak and emaciated condition, owing to his refusal to eat for several days previously, and was fed the usual quantity of milk and eggs by means of the stomach tube, but soon vomited all he had taken, and during the next twenty-four hours was not able to keep anything on his stomach, although several attempts were made. All efforts to give food by the mouth were stopped, and fourteen ounces of the infusion given daily for three days, during which time he received no other nourishment. On the fourth day he was much stronger and perfectly quiet, pulse good, tongue clean, and complained of being hungry. He was given food, which was retained, and he ate regularly with a good appetite afterwards. This

* Read at the semi-annual meeting of the Med. and Chirurg. Faculty of Maryland, November, 1893.

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patient has since been discharged from the hospital cured, but I believe he would have died from exhaustion if the infusion had not been used.

CASE 4. A. E. C., white, female, aged fifty-two years, case of acute mania. Patient was very violent, and was fed with a stomach tube, but this had to be abandoned on account of an abscess involving the mouth and throat. She was given the infusion on three successive days, but died on the fourth day from exhaustion caused by the extensive inflammation of mouth and throat.

CASE 5. E. D., white, female, aged forty-eight years, case of epileptic insanity. The epileptic seizures occur once in two or three months, and are followed by a period of depression. During one of these depressed periods she refused all food for several days, and was given the infusion on three successive days. She improved considerably and began to eat on the fourth day.

CASE 6. R. L. T., white, male, aged thirty-one years, case of simple melancholia. This patient refused to eat, and despite persistent feeding with duck and stomach tube he became weaker and took to bed in a very weak and emaciated condition. His secretions were foul and vomiting occurred frequently. The infusion was given on four successive mornings, and although during this time, over 100 hours, he did not take any food into his stomach. His condition in every respect was better than it was before receiving the infusion; his tongue became moist and clean, pulse stronger, and his mental condition was much better. He asked for food, and has so much improved that he now has liberty of the grounds, and will most likely be sent home in a short time. This patient was discharged recovered, November 19, 1893.

It is well known to every alienist that certain cases of melancholia with refusal of food, not due to illusions will gradually emaciate and die in spite of the most persistent artificial feeding, and it is in these cases that the subcutaneous infusion of nourishment will find its greatest use.

In cases of delirium tremens where the stomach will not tolerate anything, this method affords an excellent means of keeping up the patient's strength during the three or four days that the stomach is resting; also in severe cases of vomiting of pregnancy, and any case where the stomach must have rest, this method of giving nourishment will be useful.

It has the advantage over rectal feeding of not being so dangerous or so disagreeable to the patient, and of being more certain in its effects, besides it stimulates the heart, and increases arterial tension which is important in cases that are very low, as most of these will be in which this method is indicated.

I believe this method of administering nourishment can be used to advantage in a considerable number of cases by both the alienist and the general practitioner.

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**A Fours Year's Course at Jefferson Medical College.**

At a meeting of the Faculty of Jefferson Medical College, held on January 8, 1894, it was unanimously resolved to institute a compulsory four years' course with the sessions of 1895–'96.

This step was taken in order that the large clinical service of this Jefferson College Hospital (350 cases a day) might be utilized to the fullest extent in carrying out the desire of the faculty to provide advanced Medical education of a practical character.

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VACCINATION matinees have become quite the fashion in Paris. Persons belonging to fashionable society co-operate in arranging to have a doctor and a cow at an afternoon tea. The company are all vaccinated from the cow. In some of the large houses on the Champs Elysees, the cow is taken up in the elevator, and is temporarily installed in the dining-room. The cards issued bear the words: "*On Vaccinera.*"—*Ex.*

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IT IS reported that there are 700 women practicing medicine in the Russian Empire, and a new school of medicine for women has just been started in St. Petersburg, with a four years' course of study. To the support of this school the State contributes annually 15,000 rubles, and from one to three years' service in the hospitals for women and children is expected of the students before they present themselves for the final examination.—*Pub. Opinion.*

## SOME AFFECTIONS OF THE EXTERNAL AUDITORY CANAL.*

S. G. DABNEY, Louisville, Ky.

[CONDENSED.]

The most common affection of this part of the ear is accumulation and impaction of the ear wax. Frequent as this symptom is, we are yet often unable to attribute it to any definite cause. It may be due either to over activity of the ceruminous glands or to a dermatitis of the canal which prevents the passing outward of the wax as usually occurs.

Burnett has observed that persons whose sweat glands are very active are likely to be annoyed by impacted cerumen, and it has been my observation that these cases occur more often in warm than in cold seasons. Whether this is due to over-formation of wax or to its being softened and running down on the drum membrane, is open to question; but the resemblance in structure between the sweat and the ceruminous glands gives color to Burnett's suggestion, that their activity may be excited by the same cause.

An accumulation of wax is more often produced by over-zealous efforts at cleanliness than by neglect. The habit of pushing into the ear a little of the twisted end of a towel or the use of instruments of any kind in the patient's hands is much more likely to push any wax that is present further in than to remove it. The symptoms of impacted wax are so familiar as not to require mention. They are most often of sudden occurrence and very frequently are first observed after a bath, by which the wax has been so carried down as to press on the drum membrane. In such cases patient's are in the habit of saying that they have gotten water in the ear and could not get it out. It will be observed that the symptoms produced by impacted wax depend largely on the position; so long as it is loose in the canal, a considerable quantity may remain unperceived, but when pressure is made on the membrana tympani symptoms are often very annoying and may indeed be serious. A case was reported where the patient thought his ears had been effected by a stroke of lightning. An examination revealed resting against the drum membrane a mass of wax, the removal of which gave entire relief to all the symptoms.

In a certain proportion of cases the condition of the ceruminous glands seems indicative of disease of the tympanum. This is best marked in the so-called proliferous or in advanced catarrhal inflammation; in such cases there seems to be atrophy of the sweat glands and patients often volunteer the statements that their ears are dry and secrete no wax. In early catarrhal disease either of the naso-pharynx or middle ear, there is said to be an over-production of cerumen. Thus it behooves us in every case of wax in the ears to search diligently for the cause, and especially to examine the condition of the middle-ear and naso-pharynx. Yet in my own experience most cases are without any discoverable cause.

Methods of removing wax need little description. In the great majority of cases the syringe and warm water properly used are amply sufficient. When there is desquamative inflammation of the canal the syringe often fails, and I find most satisfaction in the use of Buck's curettes, delicate forceps, and occasionally a small hook; but instruments are seldom needed, and should be used only by one accustomed to aural practice. One case was reported where syringing was found insufficient; a large mass in the left ear whose central portion wax, was but whose chief bulk was made up of dried skin, the result of a desquamative inflammation, had to be gradually and laboriously picked out with curette and forceps, softening it a little with a solution of bicarbonate of soda. When the wax has been removed, we often find the canal slightly inflamed, with a tendency to desquamation. In such cases a little yellow oxide of mercury ointment (gr. i to vaseline oz. i) is an old-established and valuable remedy. When there is much scaliness and itching, oil of Cade (oz. i. to vaseline or olive oil oz. vi.), may be used with advantage.

*Diffuse inflammation of the Auditory canal,* varies widely in its symptoms and its causation. Leaving out of view those cases which occur as complications of middle ear disease, we find irritation from picking at the ear with hair pins, ear spoons, etc., among the most frequent causes. The inflammation may be gouty; it is often eczematous; it is rarely diphheritic.

Roosa states that the symptoms in the

*Read before Louisville Medico-Chir. Soc., 1893.

order of their occurrence are: itching, pain, and a sense of fullness and heat. To these I would add in many cases pain in the movements of the lower jaw. Objectively we find deafness, redness, swelling, and later often suppuration. The most variable of all symptoms is pain. Its degree depends chiefly on whether the inflammation is in the cartilaginous portion of the canal only, or involves the bony also. In the latter case it takes the character of a periostitis and is often most intense. Indeed, even the agony of acute suppuration of the middle ear is not greater in severity, and is more easily controlled than that of severe inflammation in deeper parts of the auditory canal. The most intense cases of this character which I have seen, have been in ladies whose general health was debilitated. Next to pain the deafness and itching give most annoyance. The former depends on the obstruction and varies with the degree of swelling; the latter (itching) is usually the first symptom, and the rough means used to relieve it by the patient often greatly intensifies the inflammation. Occasionally there is a mastoid periostitis complicating disease of the canal. It is manifested by the usual symptoms, but need not give the same anxiety as when it attends disease of the middle ear, as the inflammation is almost always confined to the periosteum.

In the treatment of this disease we, of course, look first for any constitutional cause such as gout, syphilis, etc. As regards local treatment: There are two points as to which experience seems to differ greatly. They are the use of poultices and the value of early incisions. It is contended by many eminent aurists that continued poulticing gives rise to granulation tissue, and does more harm than good. Thus Roosa says,—"A poultice should never be applied to or on the ear for more than a few hours. They are almost as dangerous a remedy in aural as in ophthalmic practice, etc." I have not found this the case, except when used after an incision or the opening spontaneously of an abscess. For the relief of pain and to subdue swelling, there is in my experience no substitute for the poultice, but when there is free discharge it should be discontinued. Next in value to poulticing is hot water allowed to run into the ear from a fountain syringe. The piston syringe should not be used; its force is painful. It is often well to use the poultice and hot water alternately. A salve of cocaine, menthol and carbolic acid I have found of some service in allaying the pain and itching. Of course when there is free discharge the first indication is thorough removal of this. In such cases application of nitrate of silver gives the best result.

As regards incisions into the swollen tissue: I have found them useless except to evacuate pus. The circular shape of the auditory canal holds the cut surfaces constantly in contact and prevents the relief that might elsewhere be obtained from the lessened tension. When the incision is to be made, a few drops of a four per cent. solution of cocaine should be injected hypodermatically—the syringe being used through a good sized speculum. A curved bistoury is the best instrument for the purpose, carried in over the point of greatest tension and cutting outward. With the use of cocaine this little operation is almost painless; without it, intensely painful.

In obstinate cases a blister on the mastoid is sometimes useful. Leeches, invaluable as they are in acute suppuration of the middle ear, have but little control over inflammation in the auditory canal.

I desire to report one case recently met with in practice, in connection with the paper. The patient was a gentleman about fifty years of age, who this summer had an attack of erysipelas affecting the auditory canal of the left ear. I did not see him in that disease, but did see him about four weeks after his recovery. I found the canal inflamed and swollen, and there was a slight discharge. I tried first, nitrate of silver and later all the well-known routine remedies. Although there was swelling, I did not believe there was any pus to be evacuated. I applied a blister behind the ear, as this sometimes produces a favorable result. Also used Fowler's solution internally, without effect. Finally I made an incision into the auditory canal, and without my advice the patient used hot applications for a while afterward. The result of hot applications following incision, was growth of granulation tissue in the canal. The patient left the city shortly after this and I have not seen him since. I report the case simply to show the obstinacy of some of these affections of the auditory canal; they are not dangerous yet, as this case shows, they are sometimes exceedingly tedious.

## CHRONIC RETRO-BULBAR NEURITIS.

W. CHEATHAM, M. D., A. B., Louisville, Ky.

[CONDENSED.]

The true pathology of this affection was not well understood until the first demonstration in an autopsy by Samelsohn, in 1882.

Leber, Michel and others had referred to it before, but had never demonstrated the fact by autopsy. It has been demonstrated "that the marginal fibers of the disc ends in its immediate vicinity, and, in general, the central fibers go to the periphery of the retina, while the peripheral fibers of the disc supply the central part of the retina; the papillo-macular fibers entering the eye as a wedge-shaped cluster on the temporal side of the disc occupying nearly its inner and lower quadrant."

As the title of the paper implies it is only the fibers of the optic nerve in front of the chiasm that are involved generally.

*Causes:* The principal cause is alcohol or tobacco, alone or combined; some authors say it is tobacco alone, the alcohol acting only as a depressant. Of 138 cases, 64 were from alcohol, 23 from tobacco, 45 from tobacco and alcohol combined, diabetes 3, lead 1, and sulphuret of carbon 2; other causes as cold, and especially cold blasts on the face, chloral, stramonium and syphilis are given by Swanzy.

*Symptoms:* The failure of vision is so slow usually that the patient does not discover it until it is well advanced. Only this week, a man came in with tobacco-alcohol amblyopia, whose vision was but half of perfect. The patient complains of seeing as if he were looking through smoke or a veil. The vision of the two eyes is usually about the same, which is a point in differentiating it from disease of central origin. In the beginning there is no trouble with the field of vision; later on though, there will be discovered a central negative scotoma for colors, especially green and red. This scotoma is usually oval in shape with the long axis horizontal.

The retina involved being that portion extending from the temporal edge of the disc to the outer edge of the macula. Later on the perception of white will diminish in this area, and if the disease progresses may be entirely lost. Vision is often reduced to almost nothing in this affection, but total blindness is exceedingly rare.

It is not the periodical drunkard who is liable to suffer from this trouble, but the sipper, or steady drinker, or more often the fellow who never gets drunk. The disease is more common in the male than the female, in the old than the young, for reasons easily understood. Some author has stated that it does not occur in persons under twenty years of age, yet I have a patient now only sixteen years old; cause, the abuse of tobacco and beer.

A peculiarity of the disease is that a person may be nearly blind from tobacco-alcohol amblyopia, who under treatment may recover vision, then return to his old habits, and exceed even the abuse formerly practiced, and yet have no relapse.

The ophthalmoscopic symptoms, especially in the early stage of this disease are usually negative; the optic disc may be a little hyperæmic, or present what I used to call a brick dust color and granular appearance; later on the temporal half of the disc becomes quite pale. A point in differential diagnosis I have seen made somewhere, just where I cannot now recall, is that by the inhalation of a little amyl nitrite, vision is much improved for a while. I tried this last week on a gentleman about sixty years of age, whose vision was only $\frac{1}{4}$ of perfect, the result of alcohol and tobacco abuse, especially the latter. I told him to look at the test card, and passed under his nose a glass stopper with a drop or so of the amyl nitrite on it, and he immediately exclaimed with much joy that he could see as well as ever. He demonstrated the fact by reading $\frac{1}{1}\frac{1}{1}$ or more than required in a test for perfect vision. How long this lasted I do not know as I have not seen him since. Strychnia hypodermatically in a large dose may have the same effect.

The pathological changes, as given by Samelsohn and others, in the optic nerve consists in an interstitial neuritis at its axis, commencing outside of the chiasm, preferably this portion of the nerve, and

leading to proliferative of connective tissue, and to secondary atrophy of a certain bundle of nerve fibers; the changes are analogous to those which take place in the liver and brain as the result of chronic alcoholism.

*Treatment*: The first indication is, of course, to correct the cause; promises to do so are easily gotten and as easily broken. A majority of the cases, if not too far progressed, will recover with no other treatment than the correction of the cause. Again others will need the leech, turkish bath, and strychnia; the latter preferably hypodermatically. I usually order strychnia nitrate gr. iv; aqua, ounce one—each drop contains gr. $\frac{1}{120}$ of the strychnia. I commence at gtts. ii, and increase one drop per day until the physiological effect is reached, which may be anywhere from gtts. xv to gtts. xl. Pot. Iod. is indicated also, or I often give zinc phosphide and strychnia, in pill,

## CASE OF PARALDEHYDE HABIT.

T. H. STUCKY, M. D., Louisville, Ky.

I would like to report a case of paraldehyde habit. The latter part of April I was called to see a young woman twenty-one years of age, who had previously been addicted to the use of morphine. She had been in Illinois attending the Keely Institute and had been relieved partially. I found her very restless and nervous, and prescribed valerian and assafœtida, but she was unable to take it. I then ordered three ounces of elix. paraldehyde, (Flexner), saw her the next day, when she seemed much better, and told her if she had any further trouble to let me know. I heard nothing more in regard to the case until, I think, the latter part of September, when her husband came to me and asked if his wife could not stop taking that stuff; that she had had the prescription doubled in May and filled ten times—which was sixty ounces; in June had it filled sixteen times—which was ninety-six ounces; in July filled twenty times—making one hundred and twenty ounces; in August filled twenty-three times—one hundred and thirty-eight ounces; September filled thirty times—one hundred and eighty ounces.

I went to see the patient and she stated that she drank the medicine from the bottle whenever she began to feel a little faint or nervous. I was surprised to learn that it still produced sleep and gave her decided benefit apparently, but the most interesting feature was, that I could not see it affected the heart to any marked degree. It produced absolutely no alarming symptoms, and her appearance was similar to what we see in a person addicted to strong drink—she resembled an individual who had been on a protracted spree. The paraldehyde was withdrawn the first of October entirely. She was placed in bed and watched carefully by a competent nurse, and I gave her valerian and strychnine. She seems to suffer just as one who is recovering from delirium tremens.

This patient consumed an average of six ounces of paraldehyde a day, or one hundred and eighty ounces during the month. I have never seen report of a case of this character and it struck me as being very unusual.

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One of ex-Senator Evarts's Stories.—To Mr. W. M. Evarts belongs the anecdote of the bereaved widow whose husband had such a large circle of friends that the company which she received on the evening of his interment crowded her drawing-room almost to suffocation. A lady friend of the widow edged her way up to her, and, pointing to something very bright and shining visible above the heads of the assembly in a remote corner of the apartment, whispered in her ear, "Say, is that a new eight-day clock? What d'ye gin for sich?" "It's not a clock," sobbed the disconsolate widow: "It's the dear departed. We sot him on end to make room for more company." The supposed eight-day clock was indeed the "casket," richly ornamented with silver nails, bosses, and handles, to which the dear departed had been consigned.—G. A. Sala, in *London Telegraph*.

## RETENTION OF URINE WITH HÆMATURIA.

OSCAR LEEDOM, M.D., Plymouth Meeting, Pa.

J. D. A large, powerfully built man, about fifty years of age, was taken sick with retention of urine on the 18th day of November, 1892. He had been husking corn and was on the damp ground from early in the morning until late in the evening. During the four succeeding days he managed with great difficulty, to pass a little urine, but continued at his work until the 22d, when the retention was complete, and he sent for me.

I found the patient in great distress, unable to pass a drop of urine, and the bladder tremendously distended. Upon introducing the catheter I drew off a great quantity of urine. From this time on, he had no control of the bladder whatever, the catheter having to be used twice daily. There was no pain except when the bladder became distended with urine; no tenderness upon pressure, nor any burning along the urethra.

He continued in this condition about two weeks, when, suddenly, his urine became bloody and he began passing great quantities of jelly-like mucous. This was accompanied with intense burning and distress. The pain grew severer as the bladder became empty every time the catheter was used. The urine was reddish-yellow or bright-red, at times followed by the discharge of nearly pure blood with the last few drops of urine. This continued about five days, when the urine began to clear up, the mucous disappeared and the urine returned to its natural color. The pain and burning ceased and he seemed in a fair way to recover.

A day or two after, however, the same symptoms returned in all their former intensity. The urine became bloody, filled with mucous, and loaded with shreds which looked like exfoliations from the mucous membrane of the bladder. The burning and distress returned. In a few days the urine again cleared up, to be followed by a similar recurrence after an interval of a few days. So long as the urine remained clear the patient was quite comfortable, slept well, and was comparatively free from pain. The retention still continued, necessitating the use of the catheter twice a day.

He continued in this condition until the 20th of December, when he began passing urine in the natural way. Dec. 24th. "Passes urine without much difficulty. Urine slightly cloudy from presence of small quantity of mucous. No albumin; clears up upon boiling." (The urine was not examined at any time with the microscope.)

This case was of considerable interest to me, and presents some remarkable features. The diagnosis was not clear. I feel positive that the hemorrhage was vesical, but the origin of it was not at all clear. Coming on as it did so suddenly, stopping and then recurring, to eventually cease with the return of health. The presence of a tumor, either villous vor malignant, seems out of the question. There was no history of malaria, and the absence of pain or tenderness upon pressure over the region of the bladder, seemed to exclude any serious inflammation of the mucous membrane with ulceration or necrosis. The prostate was not enlarged to any extent.

The treatment consisted in washing out the bladder twice daily, with warm solution of boracic acid and injecting a solution of glycerole-pepsin, the object being to dissolve the jelly-like mucous which came away in great quantities. Internally ergot and ex. uva-ursi were given, with morphia to relieve pain. The patient recovered entirely and has never suffered any bad effects from his illness.

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The nationality of Pasteur's patients is an interesting item. France and Algeria sent him 1,584 in 1892, and Algeria is notorious as a source of supply of bitten persons. Portual sent 96, England 26, Belgium 11, Egypt 12, Spain 14, Greece 19, Russia and the United States 1 each, Holland 14, Switzerland 3 and India 9. In Russia and elsewhere, I fancy, they have institutes of their own for the practice of Pasteur's treatment. From Madeira one patient came, his injury arising from a rabid dog which had been bitten by a Portuguese dog. Till then rabies was unknown in Madeira.—*Illustrated London News.*

## THREE CASES IN SURGERY.

C. S. COPE, M. D. Ionia, Mich.

Case I.—I was called March 31, 1890, to treat a fracture of the elbow, and found a patient with the following remarkable history: In 1820, while he was a young man of 21 years of age, he was engaged in chopping in the woods of the Empire State. Unfortunately an ax slipped from the hands of a fellow-woodsman, and inflicted a severe wound on the dorsal aspect of the left arm, nearly severing it at the elbow.

After suffering much at the hands of many doctors, he finally recovered, but with a stiff arm, obtusely flexed at the elbow. By use of shoulder and wrist, he was again able to handle his ax. But for seventy years he went through life thus mained.

At the time I was called, he had met with an accident. By slipping on the floor in a store, whither he had gone to make some purchases, he had fallen heavily, his weight coming on the crippled elbow, producing a complete fracture through the joint. Careful attention was given, but the bones did not unite. He made much complaint of the doctors of the present time, and lauded to the skies the good old doctors of the past.

But, lo! a change came over the spirit of his dream, when, after the pain and soreness were gone, he found that he could bend and extend his arm. It was with difficulty we convinced him of the fact that, instead of a return to natural conditions, we had simply a false joint, made so by the non-union of fractured bones. It was amusing to see him raise the left hand tc his head and stroke his face, a privilege he had been debarred from for so long. He lived two years after that in the enjoyment of his new elbow and passed away last winter at the advanced age of 93 years

Case II.—On the 13th of September, 1891, I was called to see Rachel P., an old lady of 89 years, who had fallen from a porch, and sustained a transverse fracture of both bones of the right forearm, two and a half inches above the wrist. Being thin in flesh, the fragments of fractured ends easily movable and the crepitus and deformity very distinct, the diagnosis was made at a glance.

The fracture was reduced at once, roller bandage applied, and with other indicated treatment she was quite comfortable.

The patient was demented and had been so for many years. This made it difficult to keep the limb in proper position, for she would at times loosen and remove the bandages. Finally we were obliged to muffle the well hand, to prevent further trouble. We gave it as our opinion that the bones would not unite, owing to her extreme age. But to our surprise, provisional callus was thrown out, and the bones made a complete union.

There was no doubt of this, for after six weeks she would, unaided, rise from her chair by placing the right hand on a table and bearing heavily, assume the erect posture.

But on December 13th, just three months from the date of the injury cited, the fracture was put to a crucial test. Wandering aimlessly about the house she came to the cellar door. This she pushed open with all her force. It opened inward, and giving way from her pressure, she was precipitated headlong down thirteen or fourteen steps to the depths below. Her groans brought speedy help, and the doctor was called in haste.

We found the right shoulder dislocated, while scalp and skin wounds and bruises were numerous. In fact, it seemed as though scarcely a part of the surface escaped contusion, but strange to relate, the fractured arm came out all right, although it was evident that this was the one advanced to save her as she fell.

The dislocation was reduced and the wounds attended to. She made a good recovery from the shock, and did nicely for two weeks, when she was seized with the grippe, to which she speedily succumbed.

Case III.—On the 19th of January, 1892, Mrs.—, was walking briskly over a broad stone sidewalk which was encrusted with ice. Her feet slipped, flew skyward and she struck heavily on her right hip. The fall was a bad one, and she was severely injured. Woman like she scrambled up, and looking to see if any one had observed her mishap, went on to her destination, and returned to her father's office

in the next block, to reach which she had to ascend a long flight of stairs. She was very pale and suffered great pain whenever she attempted to walk.—We must go back a little and state that just before leaving the office, her husband had made her a present of a new lead-pencil, which he had nicely sharpened. This pencil was carried in the pocket of the short coat she wore at the time of the accident.—When she reached home that evening she found blood on her underclothing. There was a circular wound in the skin about the centre of the buttock on the right side. The clothing was also fonnd to be perforated in places. A hole was also found in the pocket of the coat. One half of the lead-pencil was found in the coat pocket. This piece of the pencil looked as if it had been forcibly broken in two, as the end was splintered and irregular.

Search was made for the missing piece, but it could not be found. Supposing that it was in the wound, a physician was called, but could afford no relief, as the patient was nervous and apprehensive, and would not allow a thorough examination to be made.

The following evening I was called to take charge of the case. The patient had been walking around aided by crutches, and had thus caused considerable pain and distress.

By use of cocaine the wound was made painless, and a probe was passed to the depth of five inches. The wound was to the inner side of the trochanter major, nearly over the hip joint. The probe entered this and passed inward and upward toward the dorsum of the ilium.

The patient would not consent to chloroform, and was too nervous to undertake an operation without, so proceedings were stayed. We could only bide our time, and, departing, left word to recall us when she was ready to have it removed.

After much suffering, and when the wound began to discharge and smell bad, we were again summoned, and on the 11th of February relieved her of a piece of large-sized lead-pencil, three and three-fourths inches long. We had to carry the knife two inches deep to reach it, and make the wound sufficiently large to explore it with the finger, when the pencil was at once located and easily withdrawn.

Its sojourn of twenty days had sufficed to remove nearly all the paint from the pencil. There was considerable discharge of ill-looking, offensive pus.

The wound was injected daily with Marchand's peroxide of hydrogen, and the patient made a rapid recovery.

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**Preservation of Leeches.**

A subscriber writes that he received some leeches on one of the coldest days of the present winter; when he opened the container, he found them frozen stiff. He then put them into cold water, which apparently brought them to, as at the date of writing they were "lively." He now wants to know whether they will bite and draw when used. It is said that extremely cold weather sickens the leech and makes it inactive. The most satisfactory way for you to decide the question perhaps would be to make a trial with one or more of them. The following directions for the preservation of leeches may give you some information on the subject: As soon as the leeches arrive from the dealer, they should at once be removed from the box, and washed thoroughly in soft water, which should be at 60° F. The first washing rejected, they should then be placed in a jar half filled with water about the same temperature, with a piece of clean muslin placed over the mouth of the jar and covered with a perforated lid. Care must be taken that the water replaced be no colder than the water rejected or thrown away. The jar should be well cleansed inside every day or two in winter, and every day in warm weather, thus preventing the accumulation of any foreign matter along the sides of the jar, and the leeches taken out and gently rubbed between the fingers, or between the folds of a soft cloth to free their bodies of the mucous or slimy substance which envelopes them. You should guard also against the access of acrid vapors which may come in contact with the jar, such as ammonia, gas, and the vapor of mineral acids, which by their density finds a ready means of access through the porous lid to become absorbed by the water in the jar, which, after a short time would result fatally. If these precautions are carefully taken the leeches may be kept in a fine state of health, and there would be no likelihood of trouble in getting them to bite readily when applied to any part of the body.—*Pharm. Era.*

# TRANSLATIONS.*

## ACUTE RETROGRESSIVE MUSCULAR ATROPHY.

Dr. Adam Kilwicz (*Prag. Med. Wochen.* 1893) says: "All forms of muscular atrophy, either of myopathic or nervous origin, finally tend toward one end—death after a longer or shorter period." The author reports one case in which he shows that the myopathic form is occasionally able to take up a retrograde metamorphosis and end in a cure.

The patient, æt 28, having passed a healthy childhood, was never neuropathic; suffered during her third pregnancy with a grave attack of hyperemesis, making it necessary to feed her per rectum, since her stomach refused to retain anything. One day she had the misfortune to fall from a chair upon which she was sitting; she was unable thereafter to make the slightest movement.

A careful record shows that she was attacked by acute muscular atrophy of the myopathic form, having the peculiarity that the atrophy did not confine itself to the upper (*typus facio-scapulo-humeralis*) or to the lower (*typus-femero-tybalis*) extremities alone, but attacked upper and lower at the same time. The muscles of the balls, and all extensors, and, above all the min. peronæi were included.

It was quite interesting to note that as soon as the comparatively easy labor had been completed, a decided improvement took place; the contractions of the antagonized muscles became daily less, and slight movements of the affected muscles became possible. On the fifth day after parturition the patient was able to sit up; on the eighth day she could support her weight standing, and after the second week was able to walk with some assistance.

After the lapse of a few months the only traces of her illness left were the condition of the balls of the thumbs and the atrophy of the interossei muscles of the hand.

The author believes that the changes necessarily following in a pregnant uterus, proved the main factors, together with the lack of assimilation of nutritive principles, in producing the attack of muscular atrophy. This can, however, be explained only under the head of reflex actions.—*Centralb. f. d. Med. Wissen.*, 93.

—W.

## THE TREATMENT OF PRURIGO BY MEANS OF MASSAGE.

Dr. R. Hatschek, Vienna, (*Arch. f. Dermat. u. Syph.* 1893, xxv., p. 931), reports the result of eleven cases treated after the method described by Murray. Seven of these belonged tor purigo agria, and four to prurigo mitis.

The proceeding consists of simply rubbing the affected area, beginning at the peripheral end of extremities and rubbing toward the centre. The time required for one treatment, during the first few days is from ten to fifteen minutes. As improvement takes place this may be reduced to from five to three minutes. In all cases this treatment was followed by prompt relief of the troublesome itching, and a visible improvement in the infiltration of the skin.

In some cases there was a return of the small nodes, which, however, disappeared promptly after the vigorous use of massage. Two to three weeks seemed to be sufficient to produce a complete disappearance of the disease; while an occasional use of massage seemed sufficient to prevent a return.

The cases in which eczema formed a complication, massage appeared to act as an aid in its cure.—*Central f. d. Med. Wisen.* Nov., 1893. —W.

The autopsy in the case of Prince Alexander of Battenberg showed that the original cause of his illness was the lodging of a cherry stone in the vermiform appendix.—*Pub. Opinion.*

* Translated for The Medical and Surgical Reporter by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

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SATURDAY, JANUARY 20, 1894.


## EDITORIAL.

### TUBERCULOSIS IN ITS RELATIONS TO THE PUBLIC.

During the meeting of the Pan-American Medical Congress last September, the Section of Hygiene and Climatology unanimously adopted resolutions urging upon the governments of the nations represented, the necessity of enforcement by public authorities of measures directed to the limitation and prevention of tuberculosis. As might be expected, in view of the active public consideration of preventive and sanitary questions excited by the imminence of a cholera epidemic, these resolutions widely attracted attention among health authorities. Recently the State Board of Health of Michigan has announced that it will enforce throughout the whole state, the registration of tubercular cases and the disinfection of the dwellings and surroundings of sufferers from this disease. The Board of Health of the City of New York had already adopted the same precautions. Immediately after the adjournment of the Pan-American Medical Congress, the Philadelphia County Medical Society, with due deliberation and after a full discussion, formerly endorsed the judgment of the Section of Hygiene and Climatology, and appointed a committee to urge upon the Board of Health of Philadelphia, the requirement of registration of tuberculous patients and the disinfection of apartments occupied by such cases, after the removal of the occupant The matter attracted considerable public notice and afforded the daily papers an opportunity for the display of their scientific acquirements. It likewise afforded a few individual members of the city profession a chance to expose the incapability of the congregations of alleged experts, known as this or that section or society, while posing themselves before an admiring audience. The resolutions of the County Medical Society have gone into retirement, nor has any action been taken by the Board of Health. The presumption is the officials are studying up the matter with the aid of the lexicon and the quiz-compend.

The recommendation of public measures for the limitation of tuberculosis is receiving the careful consideration of health authorities of all parts of the United States, and there is good reason to hope that some public precautions will be enforced in every

state in the Union, perhaps, at no distant day.

It cannot be entertained for a moment, that the action of the section of the Pan-American Medical Congress, the Philadelphia County Medical Society and kindred associations of medical men of the highest intelligence and scientific knowledge, was taken with any undue haste or without thoughtful consideration of the difficulties and inconveniencies involved, without a full knowledge of the necessity of some practical precaution, or without deliberate determination to succeed eventually. The movement for the public limitation of tuberculosis is neither a sensation nor a fad. It is the inevitable outcome of the indefatigable spirit of research carried on with experiment and observation, by trained minds with all the modern appliances of precision at their disposal. It is not the dictum of any one observer supporting a theory, or of any small number of observers engaged in upsetting theories, but it is the consensus of opinion of medical scientists slowly crystalizing from the experiences and observations of all science.

It is not claimed that our knowledge of tuberculosis is complete—far from it; but the last dozen years have shown a marvelous amount of exact knowledge acquired by scientific experimentation and most minute observation, with the resultant accuracy of conclusions. In the realm of medical science, perhaps no demonstrations have been more conclusive than that tuberculosis is an infectious disease, whether it occurs in man or other animal, and that tuberculosis is practically never directly transmitted through heredity.

It now seems ascertained that heredity plays no part in the development of human tuberculosis, save the possible transmission of an increased susceptibility to the disease, which must, however, arise from specific infection after birth. Furthermore, it is not possible for tuberculosis to develope in the human system, no matter what the degree of susceptibility may be, without the introduction of the specific infection. There is no doubt that, as a general rule, repeated exposures to infection and a degenerate condition of the tissues invaded by the infectious material are required for the development of the disease. Almost any tissue in the human body is liable to invasion by tuberculosis in one form or another.

The lesions of tuberculosis are invariably associated with and probably caused by the local irritant action of a specific bacillus. This, the tubercle bacillus, is endowed with high vitality and great irritant qualities, though even under favorable conditions they multiply relatively slowly. While they have been cultivated artificially outside of the body, it is very sure that natural external conditions favorable for their reproduction are rarely or never present, but there is abundant proof that their virulence and power of propagation can remain latent for an indefinite time under these same external conditions. The discharges or secretions of tuberculous patients contain these bacilli in enormous numbers and constitute the media of infection. The bacilli do not occur either in the expired breath of a tuberculous person or in the exhalations of the body. So long as the secretions and expectoration of tuberculous persons retain moisture sufficient for cohesion there is no danger of infection. The bacilli cannot separate themselves from the medium containing them. But let these secretions become dried and pulverized and mingle with the dust of the atmosphere, and the tubercle bacillus has opened up to it an infinite field for operation.

This is the matter in a nut shell. Everything that comes in contact with a careless or ignorant tuberculous patient may become thoroughly infected and, in more or less degree, a constant

source of danger to those who associate with him. And when for any cause the dwelling of a tubercular case is vacated the source of infection remains in the dwelling to menace the life of future inmates unless the destruction of infectious material is accomplished by thorough disinfection. Recent researches by Dr. Flick of Philadelphia, made, in a most thorough and scientific manner, prove beyond peradventure that in dwellings known to be infected, family after family occupying them in turn, have suffered unusually from tuberculosis.

Concerning the proposed measures for limiting and preventing the spread of tuberculosis, *The Dietetic and Hygienic Gazette* for the current month says editorially:

"In so far as the propagation of the disease from man to man is concerned, the means of safety are simple, reliable and practical; but they involve the necessity for the honest and willing co-operation of the sufferer, his attendants, his physician, and the local board of health. The watch-words of safety are *registration, disinfection!* Destroy the infectious discharges at the earliest possible moment; never allow them to become dry.

Thoroughly and periodically disinfect and cleanse the apartments occupied by the sick—disinfect, before washing, his bedding and clothing, especially the handkerchiefs. After the apartments or dwelling occupied by a consumptive are vacated, either by death or removal, thoroughly disinfect and cleanse them before they are occupied by others. It is not our function to elaborate this fundamental principle of disinfection, nor have we space here to discuss its details. These, as well as other precautions, should be left to the intelligent family physician and the board of health. Anything like quarantine or restrictions of liberty of movement of consumptives, is entirely out of the question, and would, moreover, be quite impossible. On the other hand, to instruct the attendants as well as the patient in the importance and the mode of disinfection of the infectious discharges necessitates no hardships and need add nothing to the discomfort or mental anxiety of the unfortunate victim. Indeed, so soon as the consumptive becomes convinced of the absolute necessity to promptly destroy the expectoration, the chance of the individual's recovery is that moment materially brightened, for then the constant danger of repeated auto-infection is gone. What well-informed physician does not know that the disease, already at work in the lungs of his charge, is liable to spread by further infection through constant inhalation of dust carrying tubercule bacilli already thrown off from the very same lung? What experienced physician or pathologist does not know that to cough up sputum from a tuberculous lung and to swallow it instead of expectorating is to enhance the danger of engraftment of an abdominal tuberculosis upon that which already exists in the lungs, and make both more certainly fatal? Down, we say, with the puerile and senile cant we sometimes hear in opposition to registration and disinfection for the limitation of human tuberculosis! It is injurious alike to the suffering patient and to the general public.

A practical, judicious application of modern knowledge concerning the nature, mode of dissemination, prevention and management of tuberculosis would minimize the terrors and dangers created by it. This mortal enemy of man, although he has decimated our race for ages, is not a herditary conquerer. We have at last learned his tactics and stratagems, and have discovered the armor which renders his shafts harmless and the arms by which he can be routed. We can also cover those already wounded with an ægis of protection which will save many even of them from death. Should we longer hesitate to put on this armor and take up these arms in defense of mankind?"

# ABSTRACTS.

## THE ERECTILE TISSUES—THEIR PHYSIOLOGY, PATHOLOGY, AND TREATMENT.

Dr. J. J. Caldwell (*Charlotte Med. Jour.*) says: There are certain parts of the body, male and female, which, when excited, become swollen and turgid with blood and firm to the touch. The sensibilities, and indeed all of the actions of such parts appear exalted when in a state of erection. The most peculiar phenomenon in this state is the sudden and remarkable accumulation of blood in the erectile tissure at the time and as the immediate cause of the erection.

This action was formerly explained by the existence of a certain force peculiar to erectile tissue called "nervi-erigentes;" but the researches of later physiologists have discovered a peculiar mechanism in the tissue itself, by means of which the elongation is produced, viz: it depends upon pressure exercised on the veins or sinuses of the tissue by certain bands of muscular fibres; and hence the accumulation of blood as the arteries convey it freely and rapidly to the tissues. These muscular bands are supplied by nerves in much the same way as the vessels from centres located in the spinal cord, and are often called the "nerve-erigentes." But no matter whether the congestion is produced by the action of the vaso-dilator or the vaso-motor apparatus, or by direct or indirect action on the muscular appartus of the erectile tissue, we must in any case refer any influence transmitted to the parts in question to the spinal cord. This leads us back to a genito-spinal centre in the cord, vaso-motor, but as we have seen before, no nervous centre can act of its own motion, or originate action *de novo*, they must be excited to action. This being so we must look about for a suitable excitant influence to act upon the vessels so as to cause, in one way or the other, congestion. For a long time it has been regarded as probable that the spinal cord has a direct influence on the organs of generation; but it was Budge who made the definite experimental observation in regard to the influence of the lower part of the spinal cord on the motions of the generative organs. He laid bare the spinal cord in a male rabbit and at the same time exposed the testicle, the *vas deferens* and seminal vessel of one side. By irritating the exposed lumbar portions of the cord he found in numerous experiments that irritation of that part which corresponds to the fourth lumbar nerve produced active motions in the *vas deferens* and seminal vessels, the motion beginning at the testicle and being propagated toward the corresponding seminal vessels. The irritation on no other part of the cord produced such effects. These observations on the male, which have been often repeated with the same results, have also been made on the female; and movements of the uterus have been excited from corresponding points of the cord, therefore, the development and escape of the seminal fluid and graafian vesicle are attended with no small degree of nervous excitement. Actuated from the same spinal centre, both male and female, organs of generation becomes more and more congested and irritable as these phenomena increase, so that every impression, even every influence affecting these parts must be reflected to and from the spinal cord, from these to the brain and to the external genitals; hence we may readily perceive the relations existing between potency and the vaso-mator tonus of the genito-spinal centres, or impotency and the plexuses of these centres. In the latter case there could be no erection or there would be a great loss of the fluctuating powers of the genital organs, i. e., enfeeblement of secretions, erections and ejaculations of the male and a want of activity and ovulation and menstruation on the part of the female. Hence, all of the procreative powers are more or less dependent upon the aforesaid vaso-motors. The inhibitory action exerted by these sensory centres thoroughout the cord play a vitally important influence over the circulation, viz: periodical and rhythmical action of the heart and respiration, blushing, rage, pallor, and suffusion. Says John Hunter: "There is not a natural action of the body, whether voluntary

or involuntary that may not be influenced by the peculiar state of mind at the time."

Impotency in man may be caused by absence, want of development, malformation, or mutilation of the penis; by mental influence, any violent emotion operating protractedly or during coition, as want of confidence, fear of consequences, anxiety, grief, disgust, over excited desire.

By fevers and other severe diseases, the sexual organs remaining feeble after general health is restored. By injuries to the back part of the head from falls, blows, concussion, etc.; these being generally incurable, loss of power and wasting of testes and penis follow. By injuries and diseases of the spinal cord, which remove the power to copulate though desire remains and semen may be secreted. By excessive use of tobacco, which impairs digestion, and weakens nervous and muscular systems. Opium eating is injurious in like manner and from the same cause. By abuse of the sexual functions, removing the power of erection. Onanism or excessive sequal intercourse. Spermatorrhœa. Impediments to escape of semen, such as stricture of urethra in which the ejaculated fluid regurgitates into the bladder. Abnormal openings in the urethra (hypospadias and epispadias) so that the semen is not ejaculated into the vagina. By excessive obesity and large scrotal hernia.

Impotence in women may be due to firm adhesions of the *labia pudendi;* excessively developed and persistent hymen; absence, malformation, or an impervious condition of the vagina; obliteration of this canal through inflammation. A double vagina impedes but does not prevent copulation. Super-sensitiveness with spasmodic closure of the vagina (vaginismus). Tumor of the vaginia, or uterine tumors which have passed into the vaginal canal. Elongation of the cervix uteri; engorgement or induration of *labii uteri;* obliteration, obstruction, or great narrowing of os uteri or cervical canal. Closure of uterine cavity by tumors, cancers, etc. Malposition of the uterus. Acute retroflexion and ante-flexion. Inflammation affecting the uterus. Occlusion of the fallopian tubes, disease of fimbriated extremities. Irremediable procedentia of the uterus. Large recto-vaginal or vesico-vaginal fistula, or complete rupture of perineum allowing improper escape of seminal fluid. Uterine cancer, even when the vagina is involved, impedes but does prevent intercourse and fecundation.

Sterility in man arises from certain diseases, such as tubercolosis, diabetes, albuminuria, some forms of obstinate dyspepsia; in advanced stages the secretion of seminal fluid is usually stopped. Some cerebral defect, owing to which the functions of the testicles have never been called into play. Disease of testicles, tumors, cancers, repeated attacks of varicocele, though as only one gland is usually affected, these conditions scarcely produce sterility. Malposition of testes, these organs being retained in the abdominal cavity copulation being feasible with the crypsorchis, but the semen ejaculated being destitute of spermatozoa. Obstructions in the excretory ducts of the testicles; such as temporary or permanent obstructions after epididymitis, with power of copulating, but ejaculated fluid being destitude of spermatozoa. Obliteration of ejaculatory canals from abscesses near prostate leading to atrophy of the testes. Abuse of tobacco, opium, and alcoholic drinks, and syphilitic taint as well, may destroy vitality of spermatozoa.

Sterility in women arises from amennorrhœa; from exhaustion or excessive general weakness; too frequent or imperfect sexual excitement, and those versions, displacements, congestions, hysterias, paralyses, tumors, which are the prolific results of masturbation. Absence, arrest of development, or disease of ovaries, only occasional, not absolute cause, as both glands are seldom diseased at the same time. Leucorrhœa, especially when the discharge is abundant and acrid, by causing destruction of the spermatozoa before they reach the ovule. Syphilitic taint occasionally destroys vitality of ovule. In the absence of all obstructions or indications of disease, with apparent perfect moral and and physical adaptability, there are cases of sterility still existent, regretable and baffling, which if not irremedible, their hope and succor rests solely in the studious skill of the neurologist. How momentous a medico-legal precaution may be the services of such an expert in family imbroglios, dubious and unjust dismemberments of estates, prevented litigations depending upon the want of that 'glory'—an heir—is attested frequently by memorable and gratifying solutions.

TREATMENT.

While these tissues in their pathologic state may demand sanatory means and applications as comprehensive as sexual neurasthenia, with its mental hygiene electro-theraputy, baths, massage, counter-irritants, and the like, along with the well-known older remedies, I include as valuable and reliable, for the actions they are sought to produce, the following remedies: Damiana, yerba santa, saw palmetto, liquor sedans, vanilla, black haw, pichi, stylosanthus elatior.

A few cases may illustrate and break the monotony of more general assertion.

*Persistent Spermatorrhœa.*—Mr. H., of North Carolina, aged thirty, married several years without issue, owing to his persitent spermatorrhœa, which incapacitated the full act of copulation and deteriorated the vitality of the seamen. Upon presentation I found that his urethra along the whole canal was very irritable, particularly so along the prostatic portion; that the organ was continually weeping spermâtic and prostatic fluid, and that he suffered ejection during the slightest irritation, mentally and physically, and that he was melancholly and foreboding, and that his skin was cold, clammy and sallow. His general health was very much broken. He had married with the hope of benefitting these unhappy symptoms; but this was a great mistake, one that is made by many laboring under like conditions. Instead of marriage, such parties should seek as a remedy the advice and treatment of the intelligent, scientific physician, one honest and reliable, making these cases a special study. Unfortunately for the community, the advertising quacks have had the majority of these delicate and all-important cases as their greatest source of revenue. Upon passing the sound I found the urethra very tender, with a spasmodic stricture located at or near the prostatic gland. The passage of the sound was continued twice a week to dilate the urethra and to lessen its irritability. During the emission of semen, and just previous to that act, he observed a peculiar sensation or warning similar to the aura of epilepsy. Hence I placed him upon the bromides and atropine at night, and administered the nitroglycerine pills (1-50 gr. each), one three times a day, and ordered warm baths and careful diet. The effect of this treatment was to arrest his trouble, and to gradually restore him to physical and mental health. After this treatment had been continued for several months, I placed him upon tonic treatment, consisting of the fluid extract of damiana, belladonna, nux vomica and tincture of cinchona compound, with occasional applications of electricity to the spine. This, together with a select diet, added greatly to his vigor and procreative powers. All unnatural discharges have long since ceased, and his wife, several months advanced in pregnancy.

The number of cases throughout the land is legion, and ever will be until our communities are taught to value scientific and special treatment.

*Neurasthenia.*—Mr. D., aged twenty-five, a student at law, who also performed the duties of a clerk in an office controlling a large practice. His studies and duties proved too arduous an undertaking, and soon broke him down mentally and physically, being of a nervous and ambitious disposition. He suffered greatly from nervous dyspepsia and general nervous exhaustion. He lost flesh, lost sleep, and was tremulous and depressed, and suffered frequent seminal losses night and day. Upon examining the urethra, it was found to be irritable, with a continuous weeping discharge. No stricture was found. The penis was small, flabby and cold. I ordered him a vacation and administered atropine with bromides until the nervous irritation had subsided. I then gave a tonic consisting of liquor sedans and saw palmette during the day, with doses of pichi and hyoscyamus at bedtime, as required, making applications of the Faradic current locally and generally every few days. This treatment was kept up during the summer vacation, until late in the autumn, when he returned to his vocation, generally better, and greatly restored in his nervous system. With better sleep, good appetite, and genital functions normal, the use of electricity was continued a term longer when he left my care, with the advice to be more moderate in all things.

*Neurosis of Genitalia with Nervous Paralysis.*—Mr. K., aged thirty-three, was referred to me because of suffering from general nervous prostration. He is tall, athletic and active; he had lately lost his

color and vivacity; and had accuired an unaccountable dread of persons and places. He was almost a monomaniac in the fear of on-coming "loss of manhood," or paralysis of his procreative powers. Upon examination I found it was his custom to endure prolonged and arduous mental work, neglecting the regularity of sleep, diet and recreation. He had a fine constitution and physicial development. His genito-urinary organs were intact and well-developed, and proved readily amenable to treatment by proper hygiene, occasional administrations of electricity, and a tonic consisting of coca, sandal and vanilla. A few months of such treatment fully restored him in every particular. His physician deemed his mental phenomena of an abnormal and perhaps dangerous character, hence he referred him to me. All his unpleasant symptoms passed away as he gradually improved, though a case neglected long enough undoubtedly might have ended in some permanent pathological lesion.

*Impotency due to Excessive Use of Tobacco.*—Mr. G., aged 31, married, was referred to me as a case of impotency. I found him a hale man, well developed mentally and physically. His muscles were hard and elastic, and he was able to endure great physical strain. All of his organs were well developed—especially those of the genito-urinary system. After a thorough inquiry, I found that he was excessive in the use of tobacco, chewing and smoking to an alarming extent, and at times was in the habit of taking alcoholics too freely, all of which I forbade. I ordered for him a moderate diet and pills of damiana and nux vomica; also the daily application of the Faradic stimulus to the cord and genito-urinary appendages. He was to abstain from all genital exercises. He continued under treatment for several months, with most excellent results.

Tobacco and whiskey are, in my opinion, frequent inhibitors of the sexual act.

Case 92—*Inertia of Uterus.*—A young married lady, aged 22, from a fright or shock, suffered abortion during her first pregnancy. After this her menses were scant and irregular, with failing health for several years. She did not become pregnant during this time. After a careful examination, I diagnosticated a neurasthenic condition with consequent inertia of the genito-urinary organs. I ordered generous diet and hygiene, gentle exercise, and administered fluid extracts of Damiana and Haw three or four times daily, commencing with small doses and gradually increasing. After a few months the menses became more regular and pronounced. With general improvement of health and spirits, at the end of the third month of treatment she became enciente, and went through a regular term with a happy delivery.

Case 163—*Impotency.*—A gentleman of 36 years, of delicate frame, constantly complained of feeble digestion, irregular bowels and constipation. His complexion is sallow, he sleeps badly, his habits are sedentary, and he is given to literary affairs. Has been married several years without issue. His wife is buxom, active and regular. Upon examination I found his organs rather small, with the power of incomplete erection only. His semen under the glass exhibited but few evidences of life. I ordered a more active life, less study, regular hours and diet. Placed him on fluid extracts of Damiana and Stylosanthus, and after six months careful management he was greatly restored.

In cases of impotence from masturbation, accompanied by spermatorrhœa, we find morbid changes in the vesicular seminales, ejaculatory duts, bulbous portion of the urethra and prostate gland. Such cases frequently require surgical and special treatment; and in detecting and locating these lesions I have found nothing equal to photographing them by the sound in the galvanic connection, as introduced.

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**Mixed.**

She had read the advertisements
In the papers o'er and o'er,
But had gotten somewhat muddled
As to what each thing was for.

So when she had a bilious turn,
She took some Pyle's Pearline;
She scrubbed the floor with Sozodont,
But could not get it clean.

And for a torpid liver
She took Sapolio,
And put Castoria in the cake;
She got them muddled so.—Jay Kaye.
From *New York Life*, April 20, 1893.

# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*Meeting October 13, 1893.*

DR. T. L. MCDERMOTT, President in the Chair.

### MALIGNANT DISEASE OF ANTRUM—OPERATION.

DR. W. L. RODMAN: I have a specimen here which does not seem to be a bone but it is, nevertheless, the remains of a malar bone, the seat of malignant disease. It was removed to-day from a patient fifty-two years of age, female, living in Indiana, who came here with a well-marked tumor of the antrum which proved to be a malignant growth. The direction of this tumor was upward and outward instead of internally, the direction in which these tumors usually grow, making the malar bone very prominent. The operation was performed yesterday, and I was assisted by Drs. Dugan and Tuley. I cut immediately down upon the malar bone and this is the remains of it. It does not feel like bone at all, feels more like fibrous tissue. After removing the end of the zygomatic process, which was also diseased, the antrum was exposed and we removed with the curette a large growth sarcomatous in nature, I take it. The antrum was then thoroughly cauterized with zinc chloride. Hemorrhage was quite profuse but easily controled by tamponing with gauze. The patient stood the operation very well; I believe when she went on the table the pulse was 116 and at the close of the operation the pulse was 120. What is a little remarkable is the fact that this evening her pulse is only 68 and good volume.

I was then led to do this operation rather than the more standard one of excision of the upper jaw, on account of the fact that I think recent investigations have shown rather clearly that the old operation of excision of the superior maxillary bone is perhaps not a justifiable operation. Butlin, in reviewing 108 operations removing the upper jaw, states that the immediate mortality is rather more than 30 per cent., that of this 108 cases only five passed the three year limit which can be looked upon as a cure. There is very little, I think, to promise patients after excision of the upper jaw, because nearly all of them return very speedily, and, in view of the great mortality, other operations should be done if possible. The tumors affecting the upper jaw are in a very large percentage of cases malignant. In a paper read two years ago before the State (Kentucky) Society held at Louisville, I went over the subject pretty carefully and found that 76,3-10 per cent, are malignant, the larger proportion of them being sarcomatous rather than carcinomatous, and 23,7-10 per cent. benign. Of these rather more than 8 per cent. are cystic, the balance fibromas, osteomas and enchondromas.

In the case reported by me to-night, the tumor has not been subjected to a microscopical examination, but from its macroscopic appearance there is very little doubt in my own mind as to its being sarcomatous in nature.

#### DISCUSSION.

DR. S. G. DABNEY: I would like to ask whether in early stages of these growths within the antrum, the so-called Heryng test is used for illumination within the mouth. My own experience with it in diagnosticating suppuration of the antrum has been favorable. I believe if we will observe just beneath the eye, we will find in diseases of the antrum the affected side is rather darker than the other, even when there is no difference in transparency lower down in the cheek. My recollection is that this test was first used for differentiation of tumors of the antrum, to detect the solid from cystic tumors. Is its use satisfactory in making the diagnosis of tumors in the antrum?

DR. D. T. SMITH: I would like to ask the justification of any operation at all in this situation. A suppurative condition I judge could be ascertained and differentiated from others, which would naturally require operation or opening at all events. On the other hand, if operation is demanded, I should think complete excision of the jaw rather than partial excision would be preferable and promise more for the patient in the way of permanent results.

DR. W. L. RODMAN: Answering Dr. Dabney's question I have never seen the test used; it seems to me it would be a valuable means of diagnosis. It would possibly enable us to make a more accurate diagnosis in these cases, because it would show if the tumor had encroached upon the nares, as these growths nsually do.

The objection to complete excision of the upper jaw is that the primary mortality is more than 30 per cent., and if you cannot promise very decided benefits from an operation that gives so high a mortality, then it occurs to me that the operation is not justifiable. I was led to give this woman the bene-

fit of surgery particularly on the account of the fact that she was suffering great pain from pressure. I believe by the removal of the diseased bone and the thorough curettment of the antrum, the patient's life will be prolonged, and the mortality of an operation such as was done in this case I do not think is at all considerable.

DR. W. C. DUGAN (Visiting): There is another feature in this case that struck me as being very peculiar, and that is there was no encroachment upon the nares. The patient was able to breathe through the affected side without trouble, and in discussing the case at the last meeting of the Surgical Society, where the patient was shown, this fact was mentioned. It struck me then that if there ever was a favorable case for operation this was one. We were very much surprised at the operation to-day to find that the growth had extended from the malar bone to the upper portion of the antrum, rather than from the antrum outwardly. I agree with Dr. Rodman that the patient was relieved of a great deal of pain. She was unable to open her mouth before the operation, and I am quite sure she will be able to do so now, for in my opinion the pain was largely due to the tumor being beneath the masseter muscle.

DR. W. L. RODMAN: In reporting the case I neglected to mention the fact that this patient was unable to open her mouth before the operation, but as the masseter muscle was cut I am certain she will be able to do so now and masticate her food.

DR. W. C. DUGAN: I am very much surprised at the high mortality of this operation. I have had several similar operations lately without any immediate fatality, but I am like Dr. Smith—it is rather doubtful in my own mind as to whether this operation should not have been total excisions as I feel confident that we could have gotten all the growth out.

DR. W. L. RODMAN: The literature of the subject is rather conflicting: Gross states that he operated upon twelve of these cases, excising the jaw as many times, without a single death, and makes the most extraordinary statement that the operation is free from danger. Yet Butlin, in a very careful review of 108 cases, states that the primary mortality is more than thirty per cent., and only five of them lived past the three years limit, which is ordinarily regarded as the proper time to suppose that a cure has been effected. I would pay a great deal more attention to Butlin's statistics than those compiled by anybody else, as we know that his life work has been devoted to malignant disease, and he has shown most extraordinary energy in following up his cases.

#### DISCUSSION

of Dr. S. G. Dabney's paper. See page 88.

DR. J. M. RAY: One point that impressed me concerning the obstruction of the canal from wax, is the habit some people have of having recurrent attacks of accumulations of wax in the ear. I have in mind a man from whose external auditory canal I have removed twice a year for the last four years enormous accumulations of wax. His hearing powers are perfectly normal, and careful examination reveals no disease of the middle ear. Again, its proneness to occur in warm weather.

With reference to inflammation of the external auditory canal: The majority, I see, involve the outer part of the canal and are furuncular. I have seen several cases where incisions have given relief, and a few in which they seemed to give no relief whatever. I think Roosa teaches that incisions as a rule give very little relief to inflammations of the external auditory canal. One of the best means I have found to give relief is to allow the patient to lie down and pour hot water into the external canal, keeping it filled with hot water. I do not remember to have seen a case involving the mastoid periosteum as a result of external ear inflammation. There is no doubt but in furuncular inflammations of the canal, there is some general systemic condition that underlies it.

I have had under observation during the present summer a young man who has had a most obstinate attack of recurring furuncular inflammation of the external auditory canal. I saw him in four or five attacks; he suffered great pain, and at last I advised him to take a vacation and go to the country. He went up in Illinois somewhere, remaining two or three weeks, and has not had any inflammation of the canal since his return. While he was under my treatment I gave him tonics—Fowler's Solution, etc.—which seemed to have no effect. His trip to the country, getting fresh air and country food, seemed to produce a change in his condition for the better, and since his return to the city has had no recurrence of ear trouble.

DR. T. L. MCDERMOTT: In the last week I remember reading a pamphlet setting forth the fact that poultices applied externally had very little effect upon internal inflammations of the ear. In this article the author advocated the pouring of hot water current into the ear, which would in the majority of cases afford relief. It struck me as a very wise procedure, and Dr. Ray's remarks recall it.

I have under observation now a little boy, three or four years of age, who has fever, and apparently at first suffered from some bowel trouble; pain quite severe, but could not be definitely located, owing to his age. On the second night he complained of severe pain in the ear, lasting through the night. His head was kept in one position, and this symptom was so persistent as to suggest

torticollis. This morning he still complained of pain located in the ear. Temperature yesterday 103° F., this morning 102½° F. He has had a typical clonic spasm from the history elicited from the family. I believe that this child has some trouble in the middle ear not yet fully developed, which is causing the elevation of temperature. Since I have seen the case there has been no contraction of the muscles which we would expect to find in torticollis, and no tenderness anywhere. There is no contraction or dilatation of the pupils, no cough, no sore throat, no diarrhœa, and nothing indicating disease, except this obscure ear trouble.

DR. J. A. LARRABEE: I believe that the child is suffering from rheumatism, a disease frequently overlooked in childhood.

DR. J. M. RAY: There may be some middle ear trouble, but mastoid tenderness may occur from the drawing effect upon the sterno-cleido-mastoid muscle.

DR. T. L. MCDERMOTT: It is one of three things, external ear trouble, rheumatism or developing cerebro-spinal meningitis, the symptoms are not localized.

DR. S. G. DABNEY: The discussion has taken rather wider turn than the character of the paper called for. There is no doubt that hot water allowed to run for a long time is one of the best methods of treating inflammations of the external auditory canal, because the hot water reaches the drum membrane whereas poultices must be an inch more or less removed from it. I believe that the Fountain syringe is the most valuable for this purpose. Parents and nurses are very apt to use the Piston syringe, which is too forcible and adds to the irritation already existing.

As regards complication of the mastoid in inflammation of the canal: I have encountered this in two or three cases in children, but the inflammation was always confined to the periosteum over the mastoid process and did not involve the cells of the bone.

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TWO CASES OF FOREIGN BODY IN THE EAR.

DR. J. M. RAY: I will report two cases bearing somewhat upon the paper read by Dr. Dabney—cases of foreign body in the external ear. I recently had under observation two cases in which insects had gotten into the antrum ear and remaining there for some time. One case is now under observation: The patient is a young lady who while riding on a street car at night suddenly felt something enter her ear. She went home and poured something in her ear that she thought would kill the insect and the next day consulted a physician, who said there was nothing in the ear. For six weeks she had no trouble then she began to have violent earache. She suffered several nights before consulting me. Upon examination I found the canal blocked by something, I was unable to make out the nature of, she did not at first give me the history of the insect. She said it had been so long she had about forgotten the occurrence. I then began to syringe the ear and removed several pieces of black material, and upon further syringing and with a dull curette I picked out a headless insect as large as a bean; after I had syringed this all out, and examined again I could still see something lying at the bottom of the canal close to the drum membrane. The canal was so tender and inflamed that I could do nothing further toward removal, so advised the use of hot water injections. The ear suppurated in a day or two, and she went through a case of suppuration of the middle ear. After that subsided I could still see something in the canal, and with a strong solution of cocaine allowing the patient to lie on her side for some time until anæsthesia was produced I passed a dull curette behind the body and picked out the head of the insect as large as a shot and very hard, which had remained there through the suppuration and for six weeks previously.

No. 2.—The other case, a gentleman stepping off the street car one night felt something fly into his ear, and suddenly became so dizzy that he could with difficulty walk. He went home and poured oil in his ear to kill the insect. He remained very dizzy during the next day. The second day he consulted me and upon examination I discovered an insect lying in the canal. It was removed by syringing, when the patient again became very dizzy and had to lie down for a few minutes. The insect had dropped down against the drum membrane. The peculiar feature in the case is the intense dizziness caused.

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OPHTHALMIA NEONATORUM.

DR. T. L. MCDERMOTT: A lady called at my office with a little child evidently suffering from ophthalmia neonatorum. As the case was not in my line I advised that she consult an occulist. She said another physician attended her during delivery and had been treating the child's eyes since. Of course what the nature of his treatment was, or how often he visited the child, I do not know. I sent her to Dr. Ray, and I want to ask the doctor one question in regard to the subject; whether under proper treatment immediately after birth the trouble in the majority of these cases could not be averted.

DISCUSSION.

DR. M. RAY: The case referred to by Dr. McDermott belongs to an unfortunate class, the corneæ are perforated, one eye collapsed; the other seriously affected, but may retain a little sight. Ordinarily cases of ophthalmia neonatorum come on about four days after

birth and run a very rapid and often destructive course. I do not know that I can say very much about the case in question. The visiting physician evidently did not impress upon the mother the importance of the trouble, as she had not kept the eye free from pus.

At the meeting of the American Ophthalmological Society the past summer quite an extensive discussion was carried on with reference to the responsibility of the doctor in cases of ophthalmia neonatorum, and it was the concensus of opinion that cases were sometimes lost, and it did not make any difference who treated them or the method of treatment. The doctor should not be held accountable for an eye destroyed in ophthalmia neonatorum. There is one class of cases that I believe almost invariably go on to destruction, and that is in a premature child. I never saw a case of ophthalmia neonatorum in a child of seven or eight months but the eyes were seriously injured. I had a case of this nature during the summer. I saw the child three or four days after the eyes became involved aud at that time one cornea had become infiltrated; the other eye quickly became involved, and in a short time was also destroyed. The case referred to by Dr. McDermott was a seven-months child.

I believe that such children are peculiarly prone to this affection and suffer more severely from the effects than those born at full term. It is probably due to the fact that the resisting powers are greater in a child fully matured than one prematurely born.

DR. F. WILSON: What is the most successful plan of treatment?

DR. J. M. RAY: Perfect cleanliness is the best treatment I know of. I think the best local application is nitrate of silver; this to be used by some one who knows exactly how to do it. If due care is exercised I believe that a ten to twenty or even forty grains to the ounce solution of nitrate of silver can be employed with benefit. I remember a case I had several years ago in which I used a forty grain solution of nitrate of silver, stopping a purulent ophthalmia in one eye of a child, the other eye being seriously affected at the time. By thoroughly cleansing the conjunctiva and applying nitrate of silver it ran a very mild course and in less than a week the eye had perfectly recovered. The other eye in which the trouble had existed for a greater length of time, was two or three weeks recovering and with a superficial corneal abrasion. I believe the time is not far distant when all obstetricians will recognize the importance of preventive measures in these cases. I am sure such methods as those of Crede will prevent many cases. The Louisville City Hospital has during my service always been unfortunate in having a number of such cases.

DR. J. A. LARRABEE: In treating ophthalmia neonatorum I do not think it is safe to intrust the cleansing of the eye to anyone except the physician himself. I have had some nurses of large experience, and even then it is very risky the first twenty-four hours of the treatment to intrust them with the cleansing of the eye, giving the most minute directions. It is a very difficult thing to do I find. The eye shuts up like a mollusc and the more pus there is the tighter it is closed. It will hold a teaspoonful of pus. The lids come out to a level with the supercillary ridge remaining there swollen. I have had a nurse tell me there was nothing in the eye, when upon a careful personal examination a large quantity of pus has been found. Therefore, as has already been stated, I do not think it is safe for any physician to intrust this work to nurses, even trained nurses. I have used nitrate of silver by preference, getting it in just as soon as I could. I have more confidence in it than in any other agent outside of cleanliness.

DR. D. T. SMITH: If there is one thing that has puzzled me more than anything else in medicine, it has been to make up my mind as to the proper treatment for ophthalmia neonatorum, from reading books. They generally recommend nitrate of silver, but scarcely two of them agree as to the strength that should be used. Some insist that it should be very weak, others insist that very strong solutions are desirable. I am very doubtful in the average case whether nitrate of silver is required at all. I believe that Dr. Ray has solved the whole problem in saying that absolute cleanliness is the best treatment. The child's lid should be thoroughly cleaned every half hour with water about as salt as the normal tears, or at least every hour, all the pus being removed by gently pressing the under lid, and the lids never be permitted to stick together. I positively enjoin that somebody be up with the child night and day. Probably the most of us have suffered from ophthalmia at times, and know how painful a small particle of pus is under the lid. By gently pressing the lid and passing the finger over it this can almost always be removed. I have had such satisfactory results in the treatment of this affection simply using salt water, keeping the eyes perfectly clean, that I feel like using nothing else. I have employed nitrate of silver in some cases trying to follow the teaching of the latest books, then I would read the work of another author advocating a different strength of the solution, until I have found there is such a great variation that I have about come to the conclusion that any treatment which admits of such variation would

admit of being dispensed with altogether. As a rule I do not believe we visit these patients with sufficient frequency, leaving the treatment too much in the hands of the attendants. We should see them often, and insist that some one be present at all times to keep the eyes clean and taking pains to see that our instructions are understood.

DR, J. W. IRWIN: My views are a good deal in accord with Dr. Smith's in regard to the treatment of ophthalmia neonatorum. I have seen a number of cases of this disease, which come on one, two, three or four days after birth, and I have never seen a child to lose an eye or have a perforation of the cornea. Furthermore, in no instance have I had to apply nitrate of silver solution in the treatment of these affections. Had they been of gonorrhœal origin, it is possible I would not have gotten off so well. Therefore I am inclined to the opinion, so far as my experience goes, that this disease even in the majority of cases is not of gonorrhœal origin. The treatment in the cases I have seen was simple. I have had the eyes washed out clean with a weak solution of borax and water, and subsequently with one-fourth grain of sulphate of zinc to the ounce of water instilled into the eye with a dropper glass six or eight times a day. In a few instances, where the suppuration was very profuse and where it was very hard to control, I had the nurse to apply a solution of bichloride of mercury, one grain to one ounce of water, with a camel's-hair pencil once a day only. Two or three applications of this solution sufficed to put an end to the disease. This I believe to be the best means of all for controlling these disorders. When I was a student I was taught that sixty grains to the ounce nitrate of silver solution would be required in these cases. I have read in books that it takes anywhere from five to fifty grains to make a solution sufficiently strong to be effective. I have never yet had to apply to the eyes of a young child nitrate of silver in any form.

DR. S. G. DABNEY: I would like to say something in regard to both cases reported by Dr. Ray, as they are both of extreme interest. Concerning foreign bodies in the ear: I wanted to include something about this in my paper, but did not do so. A mistake that is very often made in removing foreign bodies from the ear, is to use instruments. Sir William Dalby goes so far as to say that injury is far more often done to the ear by attempted removal of foreign bodies than by the foreign body itself. In almost every case the syringe alone is sufficient for the removal of foreign bodies from the ear; and forceps, spoon, or other instrument, are both needless, and, except in expert hands, dangerous. In one class of cases the syringe should not be used, namely, when the substance is one that swells when in contact with water—peas, beans, etc. I remember one case where a child was brought to me who had gotten a bean in the ear; it had been syringed several times, but the bean had slipped deep in the canal and was swollen from the use of water in attempts to remove it, and the canal itself was already inflamed and narrowed. In that case it was necessary to give chloroform before the bean could be gotten out. It was easily removed, and in a day or two the swelling passed away. Cases of this kind, however, are very exceptional. Another case was a child who had gotten a grain of corn in the ear; the family physician had made several attempts to remove it by injections of water, but had not succeeded. The grain had been in the canal for some time, and the water had caused it to swell, so that it could not be removed except by taking it out in pieces. This is nearly always the case where the grain is not removed by the first injection of water.

As regards live insects in the ear: Patients very often go to their doctor and say they have a little bug in their ear as they can hear it. I remember one case where a small insect had gotten in the ear of a patient, and was still alive when I saw it many hours afterward, and was fluttering, but usually the insect soon dies after it gets in the ear.

I was particularly interested in the discussion of ophthalmia neonatorum. Just before the society was called to order I mentioned a case to Dr. Tuley which I saw for the first time to-day and found with a deep ulceration of the cornea. The child is now about two weeks old; the accoucheur dismissed both the mother and child six days ago, and I suppose the child was then doing well and the eyes improving. Since that time, however, the olphthalmia has not improved and now the condition of one eye is critical.

As regards the treatment of ophthalmia neonatorum—there can be no question but absolute cleanliness is the key-note to the whole situation. This carried out with care is usually alone sufficient for a cure but to hasten the cure there is nothing equal to nitrate of silver solution, and I am a little surprised that Dr. Smith should have found such diversity of opinion among writers as to the strength to be used. For ordinary purposes a two per cent. solution, ten grains to the ounce should be applied. In a report from the Presbyterian Eye and Ear Hospital of Baltimore sent out last June, Chisolm says the old plan of treatment in this disease still holds good; that is a four per cent. solution of boric acid used by the nurse for cleansing the eye as often as matter accumulates and the daily application of nitrate of silver by

the physician, usually ten grains to the ounce. This is the course of treatment I usually follow.

I was particularly interested in the point made by Dr. Ray in regard to suppuration of the cornea being so much more frequent in children who were born prematurely. This is in accord with the well known fact that disease of the cornea is most severe in debilitated subjects, even in adults, the corneal condition is often an index to the general health.

DR. H. A. COTTELL: The subjects under discussion are exceedingly interesting, not only to the specialist, but to the general practitioner. Concerning the matter of foreign bodies in the ear: I believe every general practitioner should keep an ear speculum and mirror and know enough about the anatomy of the ear to make an intelligent examination, not simply turn the patient around to the window as so many of them do and look into the ear without speculum or glass. He does not see to the bottom of the canal by that means, and many patients are allowed to go away with foreign bodies in the ear. I keep a set of ear specula and many times I have removed foreign bodies from the ear. I had the honor of removing an insect from the ear of a distinguished surgeon the other day. He came into my office stating that he "knew he had a bug in his ear, that he could hear it buzz," asking me to get it out. I took the speculum and glass, secured an illumination and detected a little brown object in the canal which proved to be a very small insect, (of the beetle order, I judge) and alive. It was very easily removed with a syringe and some water.

I have seen accumulations of wax in the ear, as you all have, which practically amounts to the same thing as a foreign body, and sometimes sets up a considerable trouble of a reflex character. But I want to have the subject of reflexes due to irritation of the external ear brought up some time for discussion.

A word or two in regard to ophthalmia neonatorum: Of course all doctors see this disease, and although I have never had a severe case to develope in my practice, I have had one or two pretty severe ones brought to me. One I remember came from another city; the eyes looked to me as if they would be destroyed. I did not have the temerity to attempt to treat the case. I sent the case to the Infirmary and asked Dr. Cheatham to see it. I remember he put the child in charge of a trained nurse and was very specific in his directions to have the eyes cleansed with considerable frequency, and that he used a solution of nitrate of silver of different degrees of strength, beginning with a weaker and going up to a stronger solution. In a few days the child was well. That child would certainly have lost its eyes if it had gone on under the treatment the country doctor was giving it.

Concerning the question of using peroxide of hydrogen in the treatment of purulent conjunctivitis: Peroxide of hydrogen ought to be the ideal remedy for that trouble, and I think the reason it is not used is that it is too irritating, owing to the acid it contains. Now there is no peroxide of hydrogen made that does not contain acid. When the Oakland Company's came out some time ago, it was received with a great deal of enthusiasm because it was only slightly acid. I took a sample bottle of the Oakland Company's and made some experiments with it, and while it was very much less acidulous than the other preparations, it still contains quite an excess of acid and is bound to be irritating. If used in the eye it would have to be diluted to such a degree that it would not have any marked effect. If chemists can make a peroxide of hydrogen which shall be neutral, they will put in our hands a very valuable agent.

DR. H. E. TULEY (visiting): During my term of service at the Sloane Maternity Hospital in New York there were 202 births; the Credé method was observed in every case, two drops of two per cent. solution of nitrate of silver being instilled into each eye immediately after birth, and there was not a single case of ophthalmia neonatorum during that time. This method is followed in every case, after birth, and I do not think they have had a case of ophthalmia neonatorum there in a long time—I know they have had none in the last thousand births.

DR. P. F. BARBOUR (visiting): While I was in the City Hospital here, we adopted a method of preventing ophthalmia neonatorum which succeeded in every case. This method was to cleanse thoroughly the child's hands with boric acid solution. It seems to me that they should receive attention. One of the first actions on the part of a child is to rub its hands into the eyes. I believe if the hands as well as the eyes are kept cleansed with some mild antiseptic, there will be much less of this trouble.

DR. T. L. MCDERMONT: In all the women we deliver in the course of many years, it is possible that we might not have a case of ophthalmia neonatorum, then again it might occur very frequently. Of course there are reasons why there should be more cases in hospital practice owing to the class of patients presenting at such an institution for delivery. Gonorrhœal infection is much more liable to be encountered there than in private practice. Our discussions of matters of this kind will bring them to the attention of other and younger physicians and I believe good will

result from greater care exercised in an endeavor by proper treatment to prevent trouble in this direction.

DISCUSSION

of DR. T. H. Stuckys' paper. See page (91).

DR. T. L. MCDERMOTT: I had an experience of similar character at the Springs this summer: A man was suffering from alcoholism and I prescribed paraldehyde in small doses. The effect was so pleasing that he consumed the whole vial, six ounces, in one day without any perceptibly bad effect. In another case at Seelbach's Hotel, in ordinary doses, it produced violent heart symptoms with evidence of poisoning. Here are two cases in which the action of this drug was directly opposite. I remember prescribing paraldehyde to another patient who was suffering from alcoholism. The druggist two weeks afterward called my attention to the fact that this man was getting from four to six ounces of paraldehyde per day, and asked if it was my wish to have it continued. I of course instructed that he be sold no more, as I did not intend for it to be continued. That case was similar to the one reported by Dr. Stucky—the man was going about the Springs taking four to six ounces of paraldehyde a day instead of whisky.

DR. J. W. IRWIN: What were the character of the heart symptoms?

DR. T. L. MCDERMOTT: Palpitation; respiration was also depressed. I understand that this patient died three or four months afterward in New Orleans, but I did not ascertain the cause of death.

DR. J. W. IRWIN: I was greatly interested in Dr. Stucky's report; it comes right within the sphere of my own observations perhaps more than any other. I have had some experience in treating persons suffering from insomnia in its various forms, and have prescribed paraldehyde a number of times. I recall one case where a patient had been taking paraldehyde for nine months every night. The dose has not been increased—one-half to one ounce every night. When he first began the use of paraldehyde it had a stimulating effect, as though he had been taking alcohol; but this effect did not last long. He then began to suffer from suffusion of the eyes with redness of the conjunctivæ and dilatation of the pupils, which would last for one or two hours after getting up in the morning. Soon after going out into the open air the pupils become normal but the suffusion of the eyes continue. He suffers from a little redness or flushing of the face; at times he shows evidence of uncertainty of gait, and in walking across the floor he staggers. He does not plant his feet on the floor as a healthy man should ordinarily do. There is no other change in his condition; it has not affected the heart, nor does it today.

No. 2.—Another gentlemen came under my observation who had spent a year or two abroad and had been taking paraldehyde for insomnia. He used Flexner's preparation in doses of half ounce at night causing sleep of six to eight hours. At the time I saw him he was suffering from a feeling of constriction about the stomach, as though a band had been tied around him. He had not been using alcohol or anything that would have put the stomnch out of order and he thought the paraldehyde might have been the cause of his trouble. I had the paraldehyde stopped had the urine examined and found a trace of albumen with hyaline casts, slightly granulated. This was the report of the chemist. After two weeks without paralydehyde, the constriction had passed away, the trace of albumen had disappeared, and so did the casts in the urine. He sleeps now without paraldehyde, takes no medicine of any kind and I believe in this case it was only imagination that he could not sleep.

I have several other cases who are using paraldehyde but these are the most striking. The largest dose I have to prescribe in any case was one ounce of Flexner's Elixir. One gentleman is taking pure paraldehyde and he thinks it is the greatest remedy in the world for insomnia. The only bad effects I have observed after the use of paraldehyde are that in one case it produced suffusion of the conjunctivæ, flushing of the face in the morning, dilitation of the pupils and a slight conjunctivitis. In a few instances in acute disease I have prescribed paraldehyde in large doses to cause sleep; I have given as much as six ounces in one night to one patient. This caused an acceleration of the pulse from ninety or one hundred to one hundred and twenty and the patient awaking from sleep rather weak and feverish. These are about the only untoward symptoms I have observed so far.

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THE MARK OF THE BEAST.—Forrester—"Did you see me making a fuss over that baby?"

Lancaster—"Yes. How much do you owe him?"—*Truth.*

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CAUSE FOR THANKS. — Teacher — Johnny, can you tell me anything you have to be thankful for in the past year?"

Johnny (without hesitation)—"Yessur."

Teacher—"Well, Johnny, what is it?"

Johnny—"Why, when you broke your arm you couldn't lick us for two months."—*Life.*

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*A Practical Treatise on Materia Medica and Therapeutics.* By Roberts Bartholow, M A., M. D. LL.D. Eighth Edition, Revised and Enlarged. New York: D. Appleton & Co., 1893.

The decennial revision of the United States Pharmacopœia involves so many changes in remedies and formulæ that a treatise on Materia Medica must, of necessity, be newly edited to make it conform to the only official standard. Formulæ have been changed as required by the Pharmacopœia, and a list of remedies, many of which have only recently appeared, have been added. An account, more or less complete, of the various new synthetical products will be here found. So important are their attributes, so largely have they come into use, and so great is the demand for true information regarding them, that a text-book would be considered wanting in thoroughness and completeness if it contained no reference to the more important of them.

We know of no work on Materia Medica and Therapeutics that we could more unhesitatingly recommend than this one, and we express the belief that this new edition will prove still more worthy of the remarkable favor which the work has enjoyed from its first appearance.

*An Outline of the Embryology of the Eye.* With illustrations from original Pen Drawings by the Author. By Ward A. Holden, A. M., M. D., New York. G. P. Putnam's Sons.

The research was carried out in the New York Ophthalmic and Aural Institute, and is based upon the examination of a great number of specimens. The chick-embryos were obtained by incubation, were hardened in Kleinenberg's or Muller's fluid, and stained with carmine and hæmatoxylin-eosin. The pig-embryos were obtained fresh and hardened in Muller's fluid after decalcifying, when necessary, with phloroglucin or hydrochloric acid mixtures, and the sections were stained mostly with hæmatoxylin-eosin. The study received The Cartwright Prize Essay for 1893.

The author presents a clear and comprehensive description of the development of the eye giving first a brief and purely schematic sketch of the processes which take place, explaining them with diagrams. He next gives an accurate histological description of the various parts of the eye in their successive phases of development, and illustrates these descriptions with careful drawings from actual preparations.

*The Child, Physically and Mentally—Advice of a Mother, According to the Teaching and Experience of Hygienic Science. Guide for Mothers and Educators.* By Bertha Meyer. Translated by Friederike Salomon Revised by A. R. Aldrich, New York; M. L. Holbrook Co.

Thirteen years have elapsed since Bertha Meyer's book "From the Cradle to the School" was translated and offered to the English speaking public. "The Child" which we now have before us, shows the same careful hand, the same endeavor to comfort, and to educate; and if the precepts here laid down be observed, blessing and health to children are bound to follow.

Many helpful suggestions are made. Throughout the entire book great stress is laid upon hygienic rules for attaining physical and mental health and educating body and mind harmoniously.

The 155 pages are deserving of a careful study.

*Surgery.* By Bern B. Gallaudet, M. D., Demonstrator of Anatomy and Clinical Lecturer on Surgery, College of Physicians and Surgeons, New York, Visiting Surgeon, Bellevue Hospital, New York, and Charles N. Dixon-Jones, M. D., Assistant Surgeon, Out-Patient Department Presbyterian Hospital, New York. Being the final volume of "The Students Quiz Series." Edited by Bern B. Gallaudet, M. D. Duodecimo, 291 pages, 149 illustrations. Cloth, $1.75. Philadelphia. Lea Brothers & Co., 1893.

The author has endeavored to present this book, not as a compend or digest of surgery, but rather as one which would *explain*. Among the principles of surgery, Inflammation is one, the clear comprehension of which seems attended with peculiar difficulties. This book elucidates this subject fully. But as it is a fact that the *varieties* of inflammation *themselves* are recognized as being either "specific" or "non-specific," and that putrefaction is a process distinct from inflammation, the author deemed it best to avoid all discussion, and to classify the bacteria as *causes* in the same way in which their effects—i. e., inflammation and putrefaction—are classified.

In addition to inflammation, three other subjects have received especial attention. These subjects are: Tumors and Cysts, Brain Surgery, and Abdominal Surgery.

*Essentials of Minor Surgery, Bandaging, and Venereal Diseases.* Arranged in the form of Questions and Answers. Prepared especially for Students of Medicine. By Edward Martin, A. M., M. D. Second Edition, Revised and Enlarged. 78 Illustrations. Philadelphia: W. B. Saunders, 1893.

This little volume, being No. 12 of Saunders's Question-Compends, has been thoroughly revised and brought up to the present standard of surgical practice. A large number of illustrations have been redrawn and engraved. Many of the omissions made in the first volume have received careful attention in this edition.

*New Truths in Ophthalmology* as developed by G. C. Savage, M. D. Thirty-two Illustrations. Publishing House of the M. E. Church South, Nashville, Tenn. 1893.

The author states that "In presenting this little volume to ophthalmologists who read," he "feels that he is doing them a service that will be appreciated." The book is considered under three parts:

Part I. New Truths in Ophthalmology. Part II. Contributions to Old Studies. Part III. Operations.

For all that is new or of any value in this little volume, the author might have satisfied his literary ambitions with a few contributions to some of our medical journals.

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*Essentials of Bacteriology.* Being a Concise and Systematic Introduction to the study of Micro-organisms. For the use of Students and Practitioners. By M. V. Ball, M. D. With eighty-one illustrations, some in colors and Fine Plates. Philadelphia: W. B. Saunders, 1893.

In this little book of some 200 pages, Bacteriology is considered under two heads, General Considerations and Technique, and special Bacteriology, together with an elaborate appendix.

That this value should so soon reached its second edition, confirms our views of its success already expressed in the review of the first edition.

*The Physician's Visiting List for* 1894. Forty-third year of its publication. Philadelphia: P. Blakiston, Son & Co.

What better evidence of success is wanting than the fact that this Visiting List has reached its forty-third year?

It contains sections on New Remedies, Incompatibilities, Poisons and Antidotes, Disinfectants, Examinations of Urine, Differential Diagnosis and Treatment of the Simpler Diseases of the Eye, Table of Eruptive Fevers, Asphyxia and Apnœa, a New Complete Table for Calculating the Period of Utero-Gestation, etc. Aside from these features, its size and weight recommend it. It is claimed to be the smallest and lightest Visiting List, published. A very great advantage, when one considers the number of articles the physician has to carry in his pockets. THE MEDICAL AND SURGICAL REPORTER has decided not to publish a Visiting List this year, but has adopted and offers for sale this one to its subscribers.

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# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

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THE UNIVERSITY MEDICAL MAGAZINE for January. Dr. James Tyson contributes a clinical lecture on

**Croupous Pneumonia.**

The author states that he has no doubt as to the propriety of bleeding in certain cases of pneumonia and the proper time to bleed is at the commencement of the disease. He thinks it is the frequent breathing next to the character of the pulse, or sometimes even the first, which should determine the taking of blood; and he would prefer even to run a little risk, if the pulse rather contra-indicated it, should the patient breathe as rapidly as in one of the cases described—72 times a minute. No symptom, as a rule is more promptly relieved by a bleeding in pneumonia than pain. He thinks fewer cases can be hurt by bleeding than we are led to suppose, that we bleed too little in this disease and if we bled more frequently more cases would get well.

Dr. M. Howard Fussell describes a case of

**Tetany.**

The case is remarkable in showing in the same individual a typical case of tetany and of epilepsy. The epileptic siezures were usually preceded by an attack of tetany, though the first and last convulsions occurred when the child was free from tetany. It would seem as if the two diseases, certainly in this patient, were simply variations of the same condition. Laryngismus stridulus was a prominent symptom in the attacks of tetany. The child *was not rachitic.* The tetany occurred in the spring and fall and disappeared in the summer and winter. The causation of an attack in this case appeared frequently to be disturbances of digestion. He concludes that tetany and laryngismus stridulus are identical conditions and not distinct diseases.

Dr. William Osler reports a case of "Parotitis in Pneumonia," which is interesting on account of the rarity of the complication. The patient died.

The same author also reports a "Case of Pericarditis Treated by Incision and Drainage." The points of interest about this case are: (1) A septic pericarditis following acute necrosis of the bones of the nose; (2) the peculiar delirium occasionally seen with pericardial effusion; (3) the onset, two weeks after operation, when the patient had been doing well, of excessive cardiac debility, probably due to myocarditis. The patient died. No autopsy was obtainable.

Dr. James Wallace contributes a scholarly paper on "Gonorrhœal Ophthalmia." Dr. Albert S. Ashmead in a short paper on "A Source of Infection on American Prairies" denies that typhoid fever can arise *de novo* and is inclined to attribute outbreaks of the disease among emigrants to infection of the streams by previous emigrant trains.

The remaining paper is by Dr. William Goodell on "The Great Medical Error of the Day." In it the author states that too much stress is laid upon lesions of the reproductive organs in the treatment of the diseases of women and too little heed is paid to the nervous system. The author cites cases to prove the position taken in the paper.

THE BRITISH JOURNAL OF DERMATOLOGY

for December. Sir Dyce Duckworth, M. D., describes

**A Case of Linear Atrophy of the Skin, with Hyperæsthesia of Adjacent Parts.**

Three months after an attack of typhoid fever the patient, a well-nourished lad of fifteen, noticed marks on his left thigh at the outer aspect, and similar ones above each ankle on the outer side of the lower legs. About the same time he experienced undue sensitiveness in the neighborhood of these marks, and also over adjacent parts, as on the outer aspect of the thigh. Examination showed several stripes of linear atrophy running across the outer part of the left thigh and on the outer side of both lower limbs above the malleolus. The knee-jerks were natural. The prognosis in any such case is good, but it is not to be expected that the integuments will ever again become natural. The therapeutical indications are to restore the general level of nutrition by good diet, and to employ such remedies as arsenic, iron, and cod liver oil. Warm sea-water baths, or peat baths, may be recommended, and feeble galvanic currents applied for short periods to relieve the hyperæsthesia. The appearance presented by the atrophic stripes is exactly that seen after prolonged distension of the integuments from obesity, lipomata, pregnancy, or chronic dropsy from cardiac or renal disease.

But in these cases the condition arises without any recognizable distension, and is probably due to neuritis involving both sensory fibres and those regulating the nutrition of the affected area.

Drs. G. G. Stopford Taylor and Frank H. Barendt report

**Three Cases of Adenoma Sebaceum in One Family.**

The author belives that the name Adenoma Sebaceum is well chosen; for it is a benign growth beginning in a gland, and the adjunct sebaceum marks its nature, both of which points the microscopical evidence completely confirms. The fact that some psychic disturbance is almost invariably present is of use in arriving at a diagnosis. The treatment is unsatisfactory, although surgical measures have improved the disfigurement in certain cases, especially where the papules are few in number. The author believe that the disease is of the nature of a congenital overgrowth of the sebaceous glands.

Dr. S. Pollitzer reports

**A Case of Xanthoma Tuberosum Multiplex.**

The noteworthy points in this case are a slight tendency to grouping in geometric figures (the parallel streaks on the left arm and the ring on the right palm) and the reddish hue apparent in some of the patches. This later fact appears to the author of especial importance in view of the relations between this form of Xanthoma and the disease as it occur in glycosuria. In a large number of cases of Xanthoma there is a distinct history of hepatic disturbance, especially of jaundice. In this case there was also probably some liver trouble, if we may interpret the attacks of severe epigastric pain referred to as due to biliary colic.

The same author also reports a "A Case of Xanthoma Diabeticorum"

Alfred G. Francis, M. B., reports "A Case of Lymphangioma Circumscriptum Cutis."

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THE JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES

for January. Dr. Albert S. Ashmead presents

**Extracts from a Japanese Work on Syphilis,**

published in Kioto in 1801. According to the author, syphilis existed and was included among skin diseases as far back as the Chu dynasty, that is about seven hundred years before Christ.

His own remedies are the following: Celestial pills which contain calomel; eliminating pills, which also contain calomel; silver nitrate pills, which contain mercury and nitrate of potash; five-element pills (having some relation to the sacred elements, wood, fire, metal, earth, water), which contain calomel; yellow illuminating powder, which contains calomel; precious-dew powder, which contains calomel; and another medicine which also contains calomel.

Poisoned diet—he means one a diet unfavorable to the patient—is advised as being unfavorable to the poison of syphilis. One poison drives out another; similia similibus. Calomel is not recommended at the beginning of syphilis.

Dr. H. Radcliffe-Crocker, of London, England, contributes a paper on "Lupus Erythematosus as an Imitator of Various Forms of Dermatitis," describing numerous cases in which the disease simulated other affections of the skin. The paper is illustrated by a beautiful chromo-lithograph of one of the cases in which the disease simulated was lichen planus.

The remaining papers in this issue are: "A Case of Mycosis Fungoides" by Dr. R. A. McDonald McDonnell; and "Clinical Notes on Skin Diseases" by Dr. W. F. Breakey.

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THE INTERNATIONAL JOURNAL OF SURGERY

for December. Dr. F. Byron Robinson contributes a paper on

**The Pathology of the Fallopian Tube**

in which he comes to the following conclusions:

1. The pathology of the Fallopian tube should be studied in regard to its structure, function and its connection with the peritoneum.

2. The inflammatory processes may be divided into three varieties, viz.: 1, endosalpingitis; 2, muscular salpingitis; 3, perisalpingitis (pelvic peritonitis).

3. The inflammatory process in the peritoneum spreads from the abdominal end of the tube in nearly all cases.

4. The nodular masses found in the pelvis are perisalpingitis and not cellulitis.

5. Autopsies demonstrate that severe perisalpingitis or pelvic peritonitis may exist, but the subperitoneal tissue will be as white as snow, as beautiful as hoar-frost.

6. Convoluted, contorted or spirally twisted tubes are accompanied by tubal colic. Such tubes are congenital or the result of subinvolution. The *tenia* tubæ enhances the condition.

7. At the bottom of most tubal trouble can be traced labor, abortion, gonorrhœa and sepsis.

8. A pyosalpinx can be changed into a hydrosalpinx and recover without operation.

9. Primary sarcoma, cancer, or tuberculosis of the tubes are quite rare.

10. No tube should be removed unless pathological conditions can be demonstrated in it, except for myoma and hysterical convulsions.

11. A prosalpinx should be removed on discovery.

12. Adhesions alone may be a sufficient cause for tubal removal on account of nerve pressure and irritation.

13. A large portion of the evil influences of tubal diseases is due to the irritation being transmitted to the abdominal brain, and then emitted to every viscus, destroying their rhythm and nutrition.

14. In removing tubes the ligature should be placed close up to the uterus, so that the menstruation will stop immediately by removing all the "automatic menstrual ganglia" belonging to the tube.

15. Uterine curetting in tubal disease should be judiciously employed. The author knows of several deaths from such procedure.

16. There is no doubt that much tubal pathology results from tinkering with the uterus, the introduction of sounds, unclean instruments, electrodes, and unnecessary curetting. Dilatation of the uterus is sometimes followed by tubal pathology.

Dr. Thomas H. Manley describes

**A Bloodless Operation for Hemorrhoids.**

The author advises local anæsthesia by means of cocaine applied hypodermically as by its means the patient is much more manageable than when under ether. The next step is thorough dilatation without which the operation will be a failure. To be painless and safe the dilatation must be gradual and steady or the muscle will be ruptured and the patient left incontinent. The third step in simple hemorrhoids is the separate treatment of each tumor by forcible pressure-massage. Before this is commenced, the entire cluster should be wiped clean and dry and then be freely mopped with the cocaine solution. Now, each hemorrhoid is separately seized, close to its base, firmly, between the tip of the thumb, index and middle fingers; first, put on a moderate, but full stretch; then twisted, and finally, so completely crushed that is reduced to a pulp, and none of the investing tunics remain, except the mucous membrane and its under stratum of fibrous tissue. When this has been completed, the entire mass is again pressed up, inside the sphincter; a suppository of opium introduced, a pad and bandage applied, when the patient is returned to bed. An active, but painless inflammation follows; and, as a rule, within two or three weeks, resorption and atrophy have so reduced the vascular masses that nothing now remains but their shrunken, diminutive stems.

Dr. Samuel E. Milliken discusses

**Diseases of the Joints in Children.**

The author cautions against the acceptance of the well known phrase "growing pains" as applied to children. Pain is no more physiological in the child than in the adult and when it occurs should be investigated by the physician. He also advises the use of an anæsthetic in any tedious examination of a joint. Its use is advisable not alone to determine the lesion more readily but also because the subsequent treatment of the child can be carried out with less resistance if pain is not caused at the first examination. Conservatism should be the motto in the treatment of joint disease in children. It is the author's opinion that excision is only advisable in extreme cases as partial arthrectomy usually meets the requirements of such emergencies.

Dr. L. J. Lusk reports a case of

**Penetrating Wound of Anterior Fossa through Orbital plate of Frontal Bone—Recovery.**

The patient had been thrown by a runaway horse against a lamp-post, driving a piece of gas-pipe, with a blunt end five-eighth inches in diameter, into the forehead a depth three of and one half inches. Her swaying body remained suspended in this position until removed by two strong men; one lifting the body, while the other pressed her head off the tube. The bones uniting to form the orbital floor were as completely removed as if it had been the work of the most skillful hand. There was also a fracture of the nasal eminence of the frontal bone. The eye-ball was uninjured except being completely separated from its attachments. Hemorrhage was quite profuse, but was controlled by cold compresses of sublimated water. An early hypodermic injection of ¼ gr. sulphate of morphine was given. The parts were thoroughly washed with hot sublimated water, 1-2000. At the point of deepest penetration, which was about three and one-half inches, the author used a 1-3000 solution in the cavity, the patient lying on her back; by turning slightly the face downward, the water ran out. After making the parts as thoroughly aseptic as possible, several strands of aseptic silk were introduced in the deepest perforation and the flaps united by interrupted sutures. The external dressing consisted of iodoform and boracic acid, and the whole covered with sublimated gauze and absorbent cotton.

Dr. A. B. Judson contributes a paper on "The Importance of Early Attention to the Disability Caused by Infantile Paralysis." In the department of the journal devoted to Railway Surgery, Dr. Emory Lanphear discusses "Meningeal Hemorrhages and their Treatment;" and Dr. George Chaffee contributes a paper on "Railway Surgery,

Railway surgeons and their Societies." This issue also includes a report of the Annual Meeting of the New York Association of Railway Surgeons.

## NEWS AND MISCELLANY.

### Eleventh International Medical Congress.

A letter directed to the undersigned by the Secretary-General of the Eleventh International Medical Congress and dated December 19th, 1893, contains the following communications:

"American members will pay on the English, French, and Italian railways single fares for double journeys, and will obtain a reduction of twenty per cent. on fares for Italian round-trip tickets.

"The documents required for their identification will be sent to you in January, and Americans intending to visit the Congress will have to apply to you for them.

"Full particulars concerning the journeys will accompany the documents.

"Messers. Thos. Cook and Son, London, Paris, Rome, and Naples, should be applied to for accommodation and for tickets for the excursions at Rome, Naples, and to Sicily. Such excursions will be arranged at Rome under the guidance of Mr. Forbes, member of several scientific societies and correspondent of the "Times"—for Naples, three days, including Vesuvius, Pompey, Capri, Sorrento, Castellamare, Bajae, etc.—for Sicily, ten days from Naples, including Messina, Taormina, Catania, Girgenti, Siracusa, Palermo, and return to Naples.

"The fares for members of the Congress will be considerably reduced and comprise hotel accommodations, carriages, guides, boats, etc.—about 70 frcs. each, for the three days, and 285 frcs. for the ten days.

"Full particulars concerning these excursions will be contained in a leaflet to be added to the instructions and documents for the journey."

From former communications the following are herewith quoted. The members' fee is five dollars, that of their wives or adult relations two dollars each. Checks or money orders may be sent to Prof. L. Pagliani. Rome, Italy. Credentials have been promised in the near future. When they arrive (none were received last year), they may be too late for many who have started or are about to start. The undersigned, who is not informed of the cause of delay, proposes to supply in as official a form as he thinks he is justified in doing, credentials which are expected to be of some practical value. The North German Lloyd has promised to recognize them. It is suggested, besides, that a passport may increase the traveler's facilities.

Only the North German Lloyd (22 Bowling Green) and the Compagnie Generale Transatlantique (3 Bowling Green) have thought fit to grant any reductions to Congressists.

The reduction on Italian railways are available from March 1st to April 30th.

A. JACOBI, M. D.,
110 W. 34th Street, New York.
January 11th, 1894.

### Excursions to the National Capitol.

The Royal Blue Line has arranged a series of personally conducted three day tours from New York, Newark, Elizabeth, Trenton and Philadelphia to Washington, under the supervision of Thos. Cook & Son, the famous Tourist Agents. The dates selected are January 25, February 15, March 8, 29, April 19, 26, and May 10 and 17. The rate from New York, Newark and Elizabeth will be $13.00, from Trenton $12.25, and from Philadelphia $11.00, which will include transfers between depot and hotel and first-class hotel accommodations at Washington. The train will leave New York on above dates from station, foot of Liberty Street, 9.00 A. M., leave Newark, C. R. R. of N. J., 8.55 A. M., Elizabeth, Royal Blue Line, 9.31 A. M., Trenton, P. & R., 10.20 A. M., Philadelphia, 12th & Market Streets, 11.26 A. M., and 24th & Chestnut Streets, 11.42 A.M., and will arrive at Washington 3.00 P. M.

The tickets will be valid for the return journey on any Royal Blue Line train within three days, including first day of sale, thus affording tourists an opportunity to visit the public buildings and places of interest in and about the Capitol.

For more detailed information call on or write Thomas Cook & Son, 261, 1225 Broadway, New York, or 828 Chestnut Street, Philadelphia.

THE
MEDICAL AND SURGICAL
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## ORIGINAL ARTICLES.

### THE PHYSICIAN.*

H. D. HOCKENBERRY, M. D, West Sunbury, Pa.

As has been the custom, it becomes my duty, as retiring President of this society, to deliver before you the "Annual Address." And in attempting this it is certainly with a good deal of trepidation, knowing my unfitness for such an undertaking. The duties of the medical profession are not such as tend to develop the powers of rhetoric and oratory.

The physician is a man of deeds rather than of words; more accustomed to silent cogitations by the sick bed or in his office, as he notes the symptoms in the case before him and attempts to explain their cause, or as he decides upon the treatment best calculated to promote the recovery of the sufferer. He lacks the experience that comes to men in other professions, who take part in public discussions, or whose duties place them behind the pulpit, or upon the rostrum of the lecture room.

But if the physician is not a "good speaker," he is a "good hearer." The very training received in the investigation of disease, in the careful and minute observations and accurate interpretation of symptoms, educates his senses, and develops his powers of observation, making of him an attentive and critical listener, and hence, my greater timidity in coming before you.

But not to weary you with my apologies, allow me to say, by way of introduction, that the meetings of this Society are a "means of grace" that none of us can well afford to lose. We need the friendly associations of our fellow physicians. We need the mutual interchange of experience and opinions. None so learned but that he may be profited by these; none with so meagre an experience but that he may furnish a suggestion of value to others. Without these, we are liable to become narrow minded practitioners, to fall into ruts, to lose interest in our work, and its duties become the "tread mill" of our existence.

But more than this, our society relations tend to destroy the spirit of envy and jealousy that is so liable to arise among men engaged in the same calling. Instead, there prevails a spirit of peace and good will. We recognize the fact that we are a brotherhood whose end is to relieve suffering humanity; to make man physically stronger, and as a consequence, morally and intellectually better, because man's moral and intellectual attributes depend upon the development of his physical organization. Having therefore the common purpose, by our united efforts we are able to accomplish the greater good.

Another year of society work is done, and we have reason for congratulations that not one of our number has dropped out of practice by reason of death or failing health. We yet present an unbroken front, able and willing and anxious to do battle against disease. As we are about to enter upon a new year with its attendant

*Annual Address before the Butler County Medical Society by retiring President.

duties and responsibilities, would it not be well to take a retrospect of the past year?

Recall its failures and successes; take an inventory of our medical experience, that we may know whether or not we have been profitable servants to the well being of society? And as we come to render an account of our stewardship, is it with the pleasing satisfaction of knowing our faith pleases, in that our talent has gained other talents? Or do we come with fear and trembling, bringing the talent entrusted to us carefully preserved in a napkin, having failed to invest it with profit? We are under obligations to society, not only to protect and preserve the medical truths entrusted to us, but as we enjoy the records of the accumulated experience of generations of the past, so we owe to the generations of the future such a use of our advantages of experience as will add to the records of medical knowledge; else we deserve to be condemned as unfaithful and unprofitable servants.

We look back over the past, not with vain and foolish longings for its past advantages and pleasures, but because the past offers the only land marks by which our future is to be directed. Nathaniel Hawthorne makes a character in one of his stories to say, "Whatever we seek to do of our own free motion, a dead man's icy hand obstructs us." It is not true. This "icy hand" of the dead past is leading us into wisdom's ways. It is the finger-board that points us towards the haven of truth.

I might also have added, in the same connection he says, "We die of the same remedies with which dead doctors killed their patients."

We know nothing except as it is revealed to us by past experience. Scientific knowledge is founded upon this. We have been sneeringly called "empirics." Yet this epithet intended as a term of reproach, is most highly complimentary, as "empiricism" is a foundation of rock upon which is built the superstructure of science, and upon this the winds and rains of criticism and opposition have no effect.

"If," says Dr. Sam'l Johnson, "no use be made of the labors of past ages, the world must remain always in the infancy of its knowledge."

Experience is the wood and stone, the brick and mortar, the iron, the brass, the silver, the gold and the precious gems which the builder uses in the construction and decoration of the magnificent temple of "Eternal and Infinite Truth." We may not be the architect who plans and supervises the building. It may not be ours to fill the places of cunning and skilled workmen. We may be but humble hewers of wood or bearers of stone; but whatever part we take in this great work let it be done honestly, carefully, thoroughly, so that the storms of time will not overthrow it. And to this temple all future generations shall come to worship, because within its holy place dwelleth the Divinity of Truth.

But not only is it proper and profitable to review the past that we may glean knowledge from the fields of experience that have been harvested, but also that we may have a true appreciation of the profession to which we belong.

"Value yourself at what you are worth," was the saying of one whom I looked on as possessing great practical shrewdness. Value the profession at its true worth is a very praise-worthy egotism. As the veteran soldiers gather around their camp-fires and recount the deeds of military skill and courage of the past, and are thereby stimulated to daring acts of valor in the 'morrow's fight, so may we, by recalling the efforts of those heroes of the medical profession who in face of all opposition and discouragements have made valuable discoveries in medical science, be stimulated to renewed efforts in our warfare against disease, that new remedies and new methods of treatment be discovered, and the sufferings of mankind alleviated.

It is with excusable pride I point to the successes of the medical profession in the past, and comparing those with what has been done by other professions and in other callings, am ready to make this assertion without fear of contradiction. That the medical profession in the importance of its work, in what it has done to overthrow ignorance and superstition, and in the unselfishness of its charity, stands second to no other calling or profession. And I say this, with all respect to the honest and faithful efforts of others, knowing that we are all members of one body of which the eye cannot say to the hand I have no need of thee.

First, as to the importance of the medical profession. That we fully comprehend this, it may be necessary to consider what is the great purpose of our lives. What is the object of all labor in the various industries of the world? Why, the struggle to gain knowledge, wealth and honor? Are these the end of our existence?

It is possible to so lose sight of the chief end of life as to make of these the end, which are but means to an end. We acquire knowledge and wealth that we may live For this torrid heat and arctic cold are endured; the ocean's storms braved. For this rivers have been bridged, mountains tunneled, forests cleared, the wilderness made to blossom as the rose, and the barren desert to bring forth abundantly. All this that man may live. Let us emphasize this truth: *The great object of life is to live.* We are born with inherent desires for life. We are constantly struggling to overcome unfavorable surroundings, to understand the laws of nature, that by bringing ourselves into harmony with these, we may live. If then, the end of life is to live, that calling that has to do with man's physical organization must be of chief importance. The physician with scalpel and microscope studies the structure of the various organs of the body. By carefully conducted experiments he learns the functions of these parts. With like care he examines the structure of diseased organs, and notes their altered functions. He searches the animal, the vegetable and the mineral kingdoms for means to restore the diseased organs to a condition of health and normal function. But not only does he cure disease but, as a guardian of the public health, he instructs the people in those laws that govern their physical being, the observance of which promotes health and lengthens life. He selects the food best suited to further the growth and development of the body; he arranges the style and fabric of clothing; houses are built according to his plans. At his direction swamps are drained, waters are purified, sewers are laid, streets are swept, pools of contagion disinfected, and loathsome plagues eradicated. The surgeon's knife is no longer a thing of terror, and under the influence of anæsthesia, the offending member is removed and many valuable lives are saved. But why the further enumeration of these valuable services when the importance of the profession of medicine is so evident.

But again, no class of men have done more to overthrow ignorance and superstition, and among none others, do we find permitted the same freedom of investigation and discussion. We are not fettered by "ancient theories" or "old time dogmas," to which we must give unlimited credence. And rejecting these does not subject us to excommunication from the profession. We value the truth not because it is old, neither because of its general acceptance, nor yet because it has associated with it some marvelous story of supernatural revelation, but because it is truth and has stood the test of rational investigation.

We are perfectly free to reject a theory, notwithstanding its age and general acceptance, if it has been weighed in the balance of scientific medicine and found wanting. And for such rejection, we are in no danger of being brought before a tribunal of inquisition and condemned to professional death. Well for a sister profession did the same freedom of search after truth prevail. Witness the trial and condemnation of Briggs, who was crucified by his brethen, between Bob Ingersol on one side and Tom Paine's ghost on the other.

The medical profession has never been found stoning Stephen, burning witches, or hanging Quakers. Accused by the priest hood before Pilate, or doing God's service in hunting to the death those who dare to preach doctrines contrary to the accepted religion, is the history of all persecution.

And "Great is Diana of the Ephesians" has been the battle cry of superstition in all ages, as its votaries have waged their cruel and unrelenting war against science. As you all know the medical profession originated in the separation of medical truths from their union with the superstitions of priest craft. Primitive man, with no experimental knowledge upon which to base a theory of disease, looked upon the pain and sickness as indicating the wrath of the Deity supposed to have created man and having unlimited powers over the work of his creation.

To understand, and to be able to appease the wrath of this offended Deity, were attributes assumed by certain ones who, by working upon the credulity of

their fellows impressed these with a belief in such pretended supernatural powers. In this way was originated the priesthood or profession of theology. That the priests might retain their hold upon mankind, it was necessary, that in their treatment of the sick, these efforts should be attended with some degree of success, and this led to the study of the phenomena of disease, and means to cure this. Thus the first medical truths were associated with priest-craft and the priests were the first physicians.

But the practice of medicine by these priest-physicians was so mixed up with the rites and ceremonies, the offerings and incantations of their religion that the truth was hidden from the public gaze, and the cures effected were supposed to have been the result of supernatural agencies. About the year 450 B. C., when the learning of Grecian philosophy was at its height, Hippocrates effected the separation of which I have spoken, and medicine divorced from priest-craft has ever since maintained a separate existence, its followers recognizing Hippocrates as the "Father of Medicine." But even though more than twenty-three centuries have passed since then, and notwithstanding the great advancement of medical science, the ancient teachings of the priesthood have retained such hold upon the minds of men, that it is no uncommon thing to hear sickness spoken of as the mysterious ways of an inscrutable and all-wise Providence, and, also, to hear the Deity importuned to allay sickness; and in the minds of many, the visits of the clergy are as necessary to the well-being of the patient, as are the visits of the physician. Superstition has a mighty hold upon the world, and with its twin-sister, ignorance, obstructs the path of progress, and shuts out the light of scientific truth.

But not only is the medical profession of first importance to the well-being of society, and a champion and an advocate of the truth, but its followers are living examples of the principles taught by the "Peasant of Nazareth," who gave to the world the commandment of Love. "I was an hungered and ye fed me, naked and ye clothed me; I was sick, and ye visited me." Where is the class of men so faithful in the performance of their duties as physicians. The profession of medicine having for its end the common good of mankind, knows nothing of national enmity, political strife or sectarian dissensions.

It dispenses its benefits without stint to men of every country, party or religion.

The physician is the good Samaritan, who binds up the wounds of the man fallen among thieves, although a priest and a Levite had passed by without being touched by the sufferings of the unfortunate man. No other class of men dare as much, risk as much for the welfare of others. Men excited by the noise of battle and stimulated by the presence of hosts of comrades, have risked their lives in the performance of most wonderful deeds of valor. The physician with no thoughts of worldly applause, with no thought of the small pittance he may receive for his services, in the slums of vice and in the midst of the filth and wretchedness of poverty, exposes himself to the deadly contagion that the poor sufferer be relieved, or that the deadly epidemic be stayed. Such an one is a thousand times more a hero than he who faces the destructive fire of cannon and musketry. Men who have passed through the horrors of war without a thought of cowardice, stand with quaking hearts and blanched faces in the presence of contagious diseases, or flee for their lives from the plague-smitten district. While the physician goes about his work of caring for the sick with a cool head and a sympathetic heart, administering medicine to relieve their sufferings and cheering words of encouragement to relieve their despondency. A veritable angel of mercy to the poor sufferers. Not only to cure disease, but to prevent it as well. No labor is too hard, no risk is too great that the cause of disease be discovered and its ravages prevented. None are so poorly paid as the physician. Much of his work lies among the poor and vicious, who are sick because of their poverty and wickedness. To these he gives his time, and very often medicines. All of which are usually received in a sort of you-are-obliged-to-do-it spirit, and little thanks for his kindness.

Even in the minds of the general public, there prevails the notion, that the physician is under greater obligations to give his services without compensation, than are men in other callings.

The miller may refuse the flour, the butcher the meat, the merchant the clothing, that the poor family be fed and clothed. But let the physician refuse to visit this same family, such a hub-bub of righteous indignation is stirred up against him as no one would have the courage to face. The reason of this is the fact that such charity is very rarely withheld. The priest may refuse his blessing to the dying sinner. But none so vile that he may not receive the kindly offices of the physician who alleviates his pain without condemning his vice.

But what of all this. If these things are true, does not such an egotistic view of the profession of medicine and its value tend to fill us with an exalted sense of our importance? That in the haughtiness of spirit we cry out, is not this great Babylon that we have built? Not so. To realize all this, to value the profession at its true worth, impresses us with the greater responsibilities resting upon us by reason of the high character of our calling, whereby we have the greater opportunities for doing good. And we dare not neglect the voice of duty that comes mingled with the groans of sick and dying.

From the position we occupy, we are able to see the great things that have been done in medicine. But in the line of our vision is also to be seen very much remaining yet to be done. Epidemics sweep over our land, in whose wake are to be heard the lamentations of the mourners who sorrow for the loss of those fallen under the blightings of the deadly plague. Men and women are dying with diseases so loathsome in character as to make of them objects of dread and disgust to all around, while their bodies are racked with most excruciating pains. The physician stands by, powerless to stay the progress of the disease or to relieve the suffering it occasions.

In our cemeteries, as we read the inscriptions upon the stones that mark where the dead are laid, we find that but very few have reached the limit of man's existence. In infancy, in childhood, and in early manhood, the greater number have passed away. And this, not because a kind Providence has seen fit to remove them from the temptations and snares of a wicked world, but because the laws of hygiene have not been perfectly understood, because the nature of contagious diseases has not been discovered, and because we have not been able to eradicate the influence of heredity. Are there not great opportunities of usefulness for us in the fields of medicine, not only the more skillful application of those truths already known, but the discovery of new truths? Before us lies the ocean of investigation, upon which we may launch our barks upon a voyage of discovery. Already there are signs of our nearness to land. There comes floating towards us strange forms of microscopic life. We have picked up the "carved wood" of cell propagation and soon we may expect to take possession of this new world of unknown truths, upon whose shores we will plant the banner and cross of Medical Science.

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**Chloralamid a Remedy for Sea-Sickness.**

Mal de mer is an ailment, to the treatment of which I directed attention at the recent meeting of the Medical-Climatological Section of your Exposition. I there stated that evidence very complete and very convincing, existed as to the utility of a solution of chloralamid and bromide of potassium, known as chlorobrom, in arresting the retching and in allaying the mental depression which accrues after the stage of active vomiting had passed. Since then evidence has been published in the *Lancet* by ship surgeons which notably proved its prophylactic action, if certain medicinal and dietetic requirements be carried out, previous to the passenger going on board ship. These requirements are simple, and need not now be mentioned. The solution is potent, palatable and safe. It is always retained, and I have no hesitation in saying that, at last, we have found a remedy for "The swooning sickness of the dismal sea."—*No. Amer. Practitioner.*

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LONESOME.—The feeling of superiority in the sterner sex is inborn.

"Mamma, do you think you'll go to heaven?" said Jack, thoughtfully looking into his mother's face.

"Yes, dear, if I'm good," said the little mother, cautiously, wondering what would come next.

"Then please be good, for papa and I would be lonesome without you."—*Kate Field's Washington.*

# COMMUNICATIONS.

## THE HYPODERMIC INJECTION OF SULPHATE OF MAGNESIUM AS A PURGATIVE.*

J. PERCY WADE, M. D.,†

In 1873, M. Luton, made the statement, that ten centigrammes of Sulphate of Magnesium injected under the skin, regularly produced purgation. Claude Bernard had previously stated that when injected into the vein Epsom Salts produced a purgative effect.

These statements appear to attract but very little attention on the part of clinicians and slight notice is given to them in works on Therapeutics. However, Dr. Horatio C. Wood (Therapeutics; 8th edition, 1891; page 722) makes a slight reference to the former, although considering the practice a very doubtful one.

Dr. Matthew Hay, who has contributed so much to our knowledge of the physiological action of the saline purgatives, asserts that the Sulphates of Magnesium and Sodium do not purge when injected into the blood, or subcutaneously. In the latter case, he makes an exception in cases where in virtue of the injection a local irritation of the abdominal subcutaneous tissue is produced, "which acts reflexly on the intestines, dilating their blood vessels, and perhaps stimulating their muscular movement." Dr. Hay also states that when injected into the blood, Sulphate of Magnesium is powerfully toxic to the system, "paralyzing first the respiration and afterwards the heart and abolishing sensation, or paralyzing the sensory motor reflex centres."

The dose that M. Luton used, and found to act as an effective purgative was ten centigrammes, equivalent to 1.54 grains. Acting upon a suggestion of Dr. Rohé, the superintendent, to subject the question to a further clinical observation, forty-six patients were selected, who suffered from habitual constipation and required from 2 ozs. to 3 ozs., of a saturated solution of Magnesium Sulphate to produce one or more free movements of the bowels.

A two-per-cent. solution of Epsom salts in sterilized water was used. The hypodermic syringe employed had a capacity of two drachms, and when not in use, was kept in carbolized oil. Just previous to use, the needle was sterilized by steam. The dose varied from 1.86 grains to 4.5 grains. The smallest dose was first tried, and at each subsequent injection was increased one-half grain, in order to determine whether a slight increase in the dose would cause a free evacuation. It was found that the small dose acted as efficiently as the slightly larger.

In only one case was the largest dose (4.5 grs.) employed. This was a woman in whom 2 ozs. of a saturated solution of Magnesium Sulphate had previously failed to produce a movement. The subcutaneous injection caused a free evacuation in seven hours.

The site of the injection was the left arm, at the outer aspect midway between the elbow and the shoulder. In none of the cases was there any local reaction at the point of injection. A small swelling or slight tenderness was produced by the distension of the connective tissue which disappeared in a few hours. No induration or abscesses occurred, and the slight discoloration of the skin passed off in a day or two.

The injection was made 100 times in the 46 patients, and was successful 67 times or 67 per cent. and failed to act 33 times or in 33 per cent.

In 53 injections it produced one evacuation of the bowels; in ten, it produced two movements, and in four it produced three evacuations.

In only two patients were the injections a constant failure and both of the patients were of the class of melancholia with habitual constipation, who resisted nearly all purgatives.

In nine cases, the injection of 1.15 grs.—one-half the average dose—was repeated in one hour and caused two evacuations in five cases; in one, three movements; in two, one; in one, failed to act at all. This action shows that a small dose repeated in a short time has a better effect than one single dose of larger size.

In ten selected cases a comparison wa made between the hypodermic injection

* From advance sheets 96th Annual Report of Med. Hosp., for the Insane.

† Assistant Physician, Maryland Hospital for the Insane.

2. Trousseau and Pidoux, Therapeutics, Vol. 2, Page 165 Wm. Wood & Co. 1880.

of Magnesium Sulphate and the exhibition of a saturated solution by the mouth. In seven cases, or 70 per cent., the injection produced free evacuation; whereas one oz. given by the mouth acted in only three or 30 per cent.

The shortest time for the injection to produce an evacuation was three hours; the longest fourteen hours—the average being seven hours.

As to the consistency of the stools—45 may be said to have been watery, resembling those produced by a free saline purgative; in 11 they were mucilaginous in character, and the remaining 11 were the ordinary stools.

No action was noticed upon the general system following the injection.

In 50 injections noticed ½ hour after the injection, no rise in temperature, pulse or respiration occurred.

The indications for the use of the drug by hypodermic injection are obvious. In cases of gastric inflammation, where a purgative is required and the stomach rebels; in abdominal surgery, where a purgative by the mouth is apt to cause vomiting and in cases where the patient is unconscious, and unable to swallow, as in apoplexy, the hypodermic use of this purgative would be valuable.

In none of the 46 cases did such indications arise, but the work was done as an experiment and to demonstrate the value of the drug as a therapeutic agent when given subcutaneously. No explanation is offered as to its physiological action. That it does act when so given is a fact.

The effect could not be attributed to suggestion, as the patients did not know with what object the injections were made; besides, insane patients are notoriously difficult to influence by suggestion.

As stated before, the injections were always made into the arm, so that the aid of reflex irritation, in the sense of Matthew Hay, cannot be invoked in explanation.

## THE RELATION OF PELVIC DISEASE AND PHYSICAL DISTURBANCES IN WOMEN. SOME FURTHER OBSERVATIONS AND RESULTS.*

GEORGE H. ROHÉ, M. D.,† CATONSVILLE, MD.

In my report for 1892, I gave the detailed history of eighteen cases of insanity in women, in whom the uterine appendages were removed for ovarian, tubal or other pelvic diseases. Since that report four additional cases were operated upon. The following table gives a summary of the cases, together with the results in each case, to December 1, 1893:

A review of the cases will show that even in apparently the most hopeless cases, a beneficial effect upon the mental functions is obtained by the removal of a persistant source of local irritation. Thus in one case of hystero-epilepsy with violent maniacal attacks, lasting over eight years, complete recovery was obtained.

In four cases of puerperal insanity, two of over five years standing, three recoveries followed the operation, and the remaining case was greatly improved.

Three cases of profound melancholia recovered sufficiently to be discharged from the hospital.

In nearly every case operated on decided physical and mental improvement were noted.

While no claim is made that gynecological operations are generally indicated in insane women, it is held that where sufficient disease exists to demand treatment on its own account, the mental disturbance of the patient should be an additional reason for early and effective interference.

In the present conservative tendency among gynecologists, there is danger of delaying radical measures too long. If this delay is injudicious in the sane, as I firmly believe it to be, it is no less in the insane where recovery of mental health may be retarded or rendered impossible, by hesitancy or neglect.

I have been subjected to criticism, some of a rather savage character, for my work in this line. Some of my critics know, confessedly, little of the great advances made by modern gynecology, while others were no less ignorant of the results of recent studies of mental pathology. I have refrained from replying to these criticisms because I could afford to await results. The facts here presented will, I am sure, be regarded by all unprejudiced minds as sufficient answer to the criticisms upon my course.

*From Advance sheets from the Annual Report of the Maryland Hospital for the Insane, 1893.

## Record of Operations upon Women with Pelvic Disease, in the

| No. of Case. | Date of Admission. | Duration of Insanity at time of Admission. | Age. | Social Condition. | Form of Insanity. | Local Disease. |
|---|---|---|---|---|---|---|
| 1 | Dec. 19, 1886. | Second attack. Ten weeks. | 33 | Married. | Puerperal mania. | Lacerated cervix. Ruptured perineum. Adherent ovaries. |
| 2 | May 21, 1890. | Four months. | 32 | Married. | Melancholia. | Lacerated cervix. |
| 3 | Feb. 26, 1890. | Three months. | 39 | Single. | Hysterical mania. | Anteflexio uteri, firm adhesion of right ovary and tube. |
| 4 | Mar. 2, 1891. | Three months. | 31 | Single. | Melancholia. | Enlarged ovaries. |
| 5 | Oct. 5, 1891. | One week. | 30 | Married. | Melancholia. | Cystic and adherent ovaries. |
| 6 | Oct. 12, 1891. | One year. | 29 | Single. | Simple mania. | Retroversio uteri, adherent ovaries. |
| 7 | May 16, 1890. | Second attack. Three days. | 37 | Married. | Puerperal mania. | Lacerated cervix, adherent ovaries. |
| 8 | Mar. 30, 1885. | Unknown. | 23 | Married. | Hystero-Epilepsy with mania. | Cystic ovaries. |
| 9 | Aug. 23, 1887. | Four months. | 39 | Married. | Puerperal mania. | Lacerated cervix, adherent ovaries. |
| 10 | Apr. 4, 1890. | Epilepsy. Ten years. | 25 | Single. | Epileptic insanity. | Ligamentary cyst size of an orange. |
| 11 | Oct 22, 1888. | Three months. | 24 | Single. | Melancholia. | Cystic ovaries, and congested and tortuous tubes. |
| 12 | July 11, 1891. | Epilepsy. Seven years. | 23 | Single. | Epileptic insanity. | Double pyosalpinx and ovarian abscesses. |
| 13 | Dec. 28, 1891. | Third attack. Three days. | 28 | Married. | Puerperal mania. | Ruptured perineum. Enlarged and prolapsed ovaries. |
| 14 | Feb. 22, 1892. | Ten months. | 43 | Single. | Melancholia. | Cirrhotic ovaries. |
| 15 | Apr. 12, 1892. | Epilepsy. Nine years. | 24 | Single. | Epileptic insanity. | Cystic ovaries. |
| 16 | Oct. 31, 1882. | Two years. | 30 | Single. | Periodic mania. | Cystic ovaries. |
| 17 | May 14, 1892. | Two years. | 29 | Widow. | Paranoia. | Cystic ovaries. Trachelorrhaphy had been done for lacerated cervix. |
| 18 | June 7, 1892. | Five years. | 30 | Married. | Periodic mania. | Lacerated cervix, retroflexio uteri, cystic ovaries. |
| 19 | Sept. 12, 1892. | Two years | 30 | Single. | Hysterical mania. | Retroverted and adherent uterus, cystic ovaries. |
| 20 | Nov. 3, 1892. | Two years. | 23 | Married. | Melancholia. | Retroversio uteri, lacerated cervix, cystic ovaries. |
| 21 | June 11, 1891. | One year. | 17 | Single. | Periodic mania. | Enlarged ovaries and tortuous tubes. |
| 22 | May 26, 1893. | Five years. | 40 | Married. | Hystero-Epilepsy with mania. | Firmly adherent ovary on right side. Ovary and tube of left side absent. Ventral hernia from a previous abdominal section. |

## Maryland Hospital for the Insane, with Results to Dec 1, 1893.

| Date of Operation. | Operation. | Immediate Result. | Ultimate Result and Remarks. |
|---|---|---|---|
| Oct. 6, 1891. | Removal of uterine appendages; restoration of perineum; trachelorrhaphy. | Recovery. | Decided mental and physical improvement. Recently phthisis developed, under which she is rapidly losing ground. |
| Oct. 13, 1891. | Removal of the uterine appendages. | Recovery. | Physical improvement. No mental change. |
| Oct. 21, 1891. | Removal of the uterine appendages. | Recovery. | Decided physical improvement. No noticeable mental change. |
| Nov. 4, 1891. | Removal of the uterine appendages. | Recovery. | Decided physical and mental improvement. Patient at nine months nearly well. |
| Nov. 4, 1891. | Removal of the uterine appendages. | Recovery. | Physical and mental improvement. Patient discharged from Hospital October 1, 1893. Four weeks later she was run over by a railroad train. This may have been a case of suicide, but there is no evidence of this. |
| Nov. 10, 1891. | Removal of the uterine appendages. | Recovery. | Physical improvement. Slight mental improvement. |
| Nov. 25, 1891. | Removal of the uterine appendages. | Recovery. | Physical improvement. Mental recovery. Discharged recovered August 21, 1892. Remains well December 1, 1893. |
| Dec. 10, 1891. | Removal of the uterine appendages. | Recovery. | Discharged entirely recovered May 12, 1892. June 30, 1893, she had two hysterical attacks, following accidental death of a relative. She was kept under observation three weeks without any return of the attack. December 1, 1893, she remains entirely well. |
| Dec 15, 1891. | Removal of the uterine appendages. | Recovery. | Great physical and mental improvement. Patient from being one of the worst and most troublesome cases in the Hospital improved so much that she could be discharged from the Hospital November 28, 1893. |
| Dec. 30, 1891. | Removal of ligamentary cyst and uterine appendages. | Death. | Died in status epilepticus. Probably septicæmia. |
| Jan. 19, 1892. | Removal of the uterine appendages. | Recovery. | No mental change. |
| Feb. 9, 1892. | Removal of the uterine appendages. | Death. | Died of Septicæmia. |
| Mar. 9, 1892. | Removal of the uterine appendages. | Recovery. | Discharged entirely recovered May 8, 1892. December 1, 1893. remains well. |
| Apr. 20, 1892. | Removal of the uterine appendages. | Recovery. | Decided physical and mental improvement. |
| May 12, 1892. | Removal of the uterine appendages. | Recovery. | Convulsions less frequent but still persist. Slight mental improvement. |
| July 14, 1892. | Removal of the uterine appendages. | Recovery. | Very decided mental improvement. |
| Aug. 30, 1892. | Removal of the uterine appendages. | Recovery. | Improved considerably, but was removed from Hospital, and is now reported worse. |
| Sept. 12, 1892. | Removal of the uterine appendages. | Recovery. | Decided mental improvement, which continues. |
| Dec. 1, 1892. | Removal of the uterine appendages. | Recovery. | No mental change. |
| Jan. 19, 1893. | Removal of the uterine appendages. | Recovery. | Complete physical and mental recovery. Discharged April 1, 1893 Remains well, December 1, 1893. |
| Feb. 2, 1893. | Removal of the uterine appendages. | Recovery. | Decided progressive mental improvement. |
| Oct. 26, 1892. | Removal of ovary and tube on right side. | Recovery. | Operation too recent to give ultimate result. |

# REPORT OF CASE OF ABSCESS OF THE BRAIN.

R. L. JOHNSON, M. D.,† ROLLA, MO.

In bringing before you a description of a single case of abscess of the brain, I have the consciousness that although it may lack in detail, there is nothing added to embellish it—that it is not written either to establish or to conform to any theory of pathologist or surgeon, but as an offering of facts. It is only by observing and reporting facts accurately, that data are accumulated, from which general principles are deduced. No one surgeon has in his life enough cases of abscess of the brain to furnish all the data needed for the thorough establishment of rules of treatment. Therefore it becomes the duty of every practitioner to observe carefully and report accurately all cases coming under his observation. This becomes all the more a duty when we remember that these opportunities always imply suffering and risk of human lives and should, therefore, be carefully economized.

That rules of treatment are not thoroughly established, I find from the recent literature of the subject and also from conversation with a good friend of mine, an eminent surgeon in this city, who kindly told me I had not treated my case in the most approved style; for this I expressed my regrets, for had I done so, I might have been able to make my report more complete, by giving a description of the *post mortem* appearances.

On November 5th 1892, I was called to see William M. aged fifteen years.

*History and subjective symptoms*:—I was told that he received a blow upon the head, from an old lime-encrusted white wash brush, thrown at him, which had knocked him senseless for a while; that he had a slight dull headache and was somewhat constipated, and that he had been feeling badly for several days. I was only told of this accident after I had decided that he was suffering from a torpid state of the liver and bowels. Upon a careful examination of all objective symptoms, I found a slight depression an inch posteriorly to the external angular process of the frontal bone, a half an inch in length, over the portion contiguous to the sphenoid; the skin was not broken at all; the tongue was large and furred; his pulse rather slow and the temperature normal; he was dull and slow of speech, but perfectly intelligent; there was entire absence of paralysis, motor or sensory; his sight was good and the pupils responded equally and promptly to light. I gave a purgative and advised quiet for a few days and requested to be notified if he did not get well promptly. During the next two weeks he was not seen; he was at work—hard work—hauling stone. At the end of that time, after hard riding horseback, headache, which had troubled him some, became rather severe; he was given potassium bromide freely, which relieved it to a great extent. On the 30th, and on the 1st, 4th, and 9th of Dec., I saw him and found him getting thin; his tongue coating more and more; his countenance dull and heavy, his speech slow, cerebration perfect but slow, answering questions slowly but correctly; headache most of the time; there was no fever at any time. Although his countenance and general appearance suggested typhoid fever, there was never any rise of temperature or increased frequency of pulse. On the 15th his pulse was below sixty and halting, a hesitating pulse; his bowels would not move without an active cathartic; no paralysis; pupils always responsive. On the 15th I insisted on consultation with reference to trephining. Dr. T. J. Jones agreed as to the necessity of the operation, and Drs. Rowe and Carpenter were invited to be present and kindly assisted me.

A Y-shaped incision being made in the scalp, the trephine was applied to the frontal bone just below the temporal ridge and at a point corresponding internally with Broca's convolution. On attempting to elevate the depressed portion, it was found to be much comminuted, the fragments setting nearly at right angles to the plane of the skull; these fragments were carefully removed and the sharp edges of the skull were rounded off, the dura mater, which was was not torn and which was of a dark-red color, slowly rose up to its proper level, but did not bulge into the opening at all. To the touch it felt softer

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than the brain, suggesting the presence of some fluid under it, but it was neither tense nor elastic. On consultation it was not deemed advisable to open it then as it could be done afterwards if he was not relieved. After the operation his general condition improved for a day or two; he became more cheerful and looked better, having lost the listless apathetic countenance. His pulse, however, continued as slow as before and his bowels remained constipated. On the night of the 19th, four days after the operation, it was observed that he did not use his left hand, which was not completely paralyzed, however, but so feeble that he could scarcely move it, while his grip was almost imperceptible. Paralysis of the left side of the face was now marked. Patellar reflex was absent (this was the case before he was trephined.)

There is now also a partial paralysis of the left leg. The pupils remain responsive to light. There has never been any impairment of vision or of power to move the eyes. On the 20th I opened the incision, which had healed by first intention, for about half an inch and pressed with the end of the grooved director upon the dura mater, and was satisfied that it was now tense and elastic. I then used a fine trocar and canula twice the size of a large hypodermic needle, pushing it downwards and slightly backwards (as he lay) one and a half inches before I reached pus. I then pushed in a straight bistoury and upon turning it pus flowed freely—"laudable pus." While it was flowing a rubber drainage tube was inserted one and a half inches into the wound and the pus continued to flow through and by it. The amount was estimated at three ounces, but it was not measured as it ran out freely on cloths and into the basin. The wound was dusted with iodoform; a thick compress of sublimate gauze was bound on; the drainage tube was brought through an opening in the compress and the end overlaid with sublimate cotton, and over all parafine paper. The relief from the operation was prompt. Before the opening of the abscess the pulse was forty-eight, and he appeared deaf and would neither answer nor move. In fifteen minutes he was reviving, and before I left the house, about an hour, he was smiling and talking freely and promptly. By the afternoon a remarkable change had taken place, instead of a shrunken, pale countenance he had some color; his lips were full and red and his pulse had gone up to eighty. The next day I attempted to syringe the abscess with a siphon, but there appeared to be but a very small cavity, some small clots, a little pus, and what appeared to be lumps of soft, broken down brain tissue. The next day only a little pus and bloody serum came away when I removed the tube, which I replaced. A few days after, as there was no discharge through the tube, I dilated the opening with a grooved director and got a teaspoonful of pus. From that time there was no further trouble of any kind; his pulse fluctuated from 65 to 82; he had no fever. Sordes, which I forgot to mention, cleared off; his tongue cleaned; his appetite became good and his bowels moved regularly without the aid of a cathartic. The changes in his physical condition appeared as remarkable as those in his nervous and mental phenomena. He rapidly progressed to perfect recovery and is now, one year after, at regular labor and apparently well, physically and mentally.

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THE latest scare in microbes has been started by Professor Uffelman, of Rostock, who infected a letter with cholera bacilli, and put it into a post bag. When the letters were taken out, twenty-three and one-half hours later, the bacilli were still there. Bacilli were also found living on post cards twenty-four hours after infection. The micro-organisms were found to die rapidly when placed upon coins. A fly charged with cholera bacilli was afterwards placed on some beef. A little later the meat was found to be swarming with bacteria.—*Scientific American.*

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WHEN a glass stopper sticks in the bottle, pass a strip of woolen cloth around the neck of the vessel and seesaw it backward and forward. This friction heats and causes the neck to expand, so that the stopper becomes loose. On this principle of expansion by heat a tight screw may be drawn from a metal socket with a cloth dipped in boiling water.—*Scientific American.*

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THE truly great physician is one who never speaks ill of his medical brother. He is dead.—*Medical Record.*

# A STUDY OF THE URINALYSES OF 110 CASES OF INSANITY*

## ADMITTED TO THE MARYLAND HOSPITAL FOR THE INSANE FROM NOVEMBER 1, 1892, TO OCTOBER 31, 1893.

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The systematic examination of the urine of the inmates of our public asylums and hospitals is a feature in diagnosis that has heretofore been neglected by the great majority of our asylum physicians. In those Hospitals where the examination of the urine, both chemical and microscopical, has been performed as a routine practice, the results have demonstrated the wisdom of the procedure. It is an unquestionable aid to a comprehensive diagnosis in many cases; a practice of precaution enabling the physician to adopt prophylactic measures before grave symptoms occur to warn him of the necessity for immediate therapeusis.

Much unfavorable comment has been elicited from those interested in urinary anomalies, by the fact that the physicians of our insane hospitals have persistently neglected the study of the urine of their patients.

About two years ago, Bondurant of the Alabama State Hospital, who has long insisted on a more comprehensive study of this subject, especially in its relation to Bright's disease, addressed a circular letter to Asylum Superintendents thoroughout the country, endeavoring to ascertain how many insisted on the examination of the urine of all cases admitted. He found to his surprise that only about a half-dozen in the country, made any effort towards a general examination of all cases admitted and that the great majority gave little attention to the subject, except in cases where the symptoms pointed to kidney disease and an examination of the urine seemed necessary to verify the diagnosis.

The writer has been unabled to find on record a single investigator who has written on the general subject of urinary anomalies of the Insane. It is true that a few have studied the causative relation of Bright's disease to insanity and reported isolated cases exhibiting urinary anomalies in general paresis and epileptic insanity, yet no reports have been recorded of a general chemical urinalyses of the insane.

In the tables given below efforts have been made to bring out all features of interest, both from a clinical and a chemical point of view, and notes have been made of all unsual cases. Abnormal ingredients and normal ingredients in excess will be briefly discussed and the clinical history of some of the cases presented by way of comparison with similar cases reported from other sources.

ALBUMEN. Considering each abnormal ingredient in the order of its clinical importance, albumen presents itself chief and foremost among those to follow.

The frequency of Albuminuria among the insane is a much disputed question. The reports recorded by writers on this subject are very contradictory to each other. Recent investigators, among them Dr. Christian of the Eastern Michigan Asylum,[1] Dr. Alice Bennett of the Norristown Asylum,[2] Dr. Tuttle of McLean, (Mass.) Asylum[3] and Dr. Bondurart of the Alabama State Hospital,[4] conclude that Albuminuria is very frequent among the psychoses and that bright's disease is a very prominent etiological factor in the production of insanity.

The last mentioned observer who has made a close study of the subject examined 1336 cases of various forms of insanity and found albumen in about 19.5 per cent. of all cases examined.

Dr. Amelia Gilmore of the Philadelphia Hospital for the Insane,[5] says that 25 per cent. of the admissions to the female department of the hospital give evidence of kidney disease by the presence of albumen and casts in the urine.

* From advance sheets of Hospt. Reports for 1893.

†Clinical Assistant, Maryland Hospital for the Insane.

1 Journal of the American Medical Association, March 23, 1889.

2 Alienist and Neurologist, Vol XI, No. 4.

3 American Journal of Insanity, April, 1892.

4 Journal of Mental and Nervous Diseases, November, 1892.

5 Journal of Mental and Nervous Diseases, August, 1893.

Only 9.9 per cent. of all cases admitted to the Maryland Hospital for the Insane during the past year had albuminuria, either of the pregnant or transient nature.

The variation in the percentage of cases affected, as reported by the observers quoted above, is explainable on the grounds that some forms of insanity contain a higher percentage of albumen in their urine, than others, and that the cases admitted and examined were plentiful in those varieties of mental disorder that are marked by the greater or less frequency of albuminuria.

On consulting table No. 2, on another page, it will be seen that the highest percentage of albumen was found in mania (12.1 per cent.) and epileptic Insanity (20 per cent.). These results are in accordance with those of many other observers but directly opposite those of Dr. Tuttle, as reported in the afore-mentioned paper. He finds his highest percentages in melancholia (40.2 per cent.) and general paresis (40 per cent.); compared with my results of 7.4 per cent. for the former and a total absence of albumen in the latter. This total absence in general paresis may be accounted for by the fact, that with one exception the urine was examined during the first stages of the disease. His conclusions in dementia agree with mine, both tables showing a trifle over 5 per cent. of cases of albuminuria.

Dr. Max Koppen[6] "finds that the presence of albumen in the urine of the psychoses apparently depends on the height or degree of the delirious element in the disorder."

Furstner, quoted by Tuke, found albumen in the urine of all cases of delirium tremens and demonstrated that the amount was directly proportioned to the intensity of the delirium.

My observations are directly in accordance with the above statements.

Thus it is found most frequently in acute and acute delirious mania and all psychical states attended with delirium whether of centric, excentric or toxic origin. Delirium is essentially an aggregation of psychical manifestations of a reflex nature, attended with exhausting symptoms, such as insomnia; anorexia; great restlessness and often slight fever, altogether presenting all the factors essential to increased tissue waste. The kidneys, overworked by increased elimination, undergo structural changes which are enhanced in degree by the high vascular tension and the arterial changes consequent on impoverished nutrition.

The highest percentage of albumen in the list was found in epileptic insanity (20 per cent.). The specimens examined were taken at random and usually during the interval between the paroxysms. By repeated examinations in one case it was noted that the amount of albumen was materially increased directly after the paroxysm.

Huppert[7] goes so far as to claim "that albumen appears in the urine of every epileptic soon after the paroxysm and that the amount depends on the severity of the convulsions."

Voison and Perron[8] found albumen in 50 per cent. of cases of "grand mal" and 100 per cent. of cases of status epilepticus.

In opposition to the above statements, Dr. Wm. Browning,[9] in an article on the epileptic intervals says "any special frequency of albuminuria in epilepsy has been disproved."

My examinations have convinced me that albuminuria is very frequent among the epileptic insane and that the amount of albumen passed with the urine is, in most cases, directly proportioned to the frequency, duration and intensity of the paroxysms.

The physical symptoms of the ten cases containing albumen vary greatly. Three of them are evidently chronic interstitial nephritis as shown by the following brief clinical histories.

No. 7. Mrs. E. A. F., aged 55 years, recurrent mania. When admitted in Dec. '92 was unable to walk. Physical examination revealed apparent cardiac dilatation with compensatory hypertrophy; cardiac mitral regurgitant murmur; atheromatous vessels; abdomen enlarged and distended with fluid; lower limbs œdematous and varicose, their surface covered with chronic superficial ulcers, and liver enlarged. One week after admission laparotomy was performed by Dr. Rohé and the hospital staff. Two gallons of fluid was evacuated from the peritoneal cavity.

6 American Journal of Insanity, Vol. XLVI, No. 1.

7 Tuke's Psychological Medicine, Page 1348.

8 American Journal of Insanity (abstract), Vol. XLIX, No. 1.

9 Journal of Mental and Nervous Diseases, Vol. XVIII, No. 7.

Recovery complete with improved mental condition. Albumen still present in small quantity.

No. 32. Mrs. E. K., aged 75 years, dementia. Plethoric habit; lower limbs œdematous; atheromatous arteries; hypertrophied heart and high arterial tension. Albumen constantly present.

No. 98. John J. D., aged 78 years, senile dementia. Died two months after admission. Urine contained both albumen and sugar. Specific gravity 1043. This case was unusually interesting from a pathological standpoint. It will be further discussed under the caption of sugar on another page. The post-mortem notes read as follows:

KIDNEYS. Both enlarged and very firm; cortical substance much diminished; capsule adherent; large cyst on right kidney containing three ounces of fluid; smaller cyst on left organ.

HEART. Greatly hypertrophied, especially the left side. Valves normal. Calcareous plates in aorta; and evidence of general arterio-sclerosis. The other cases present no special features of interest. No. 45 is a case of lactational insanity in which the albumen disappeared as improvement ensued. No. 91 is a case of epileptic insanity which presents the usual features of this form of insanity. Nos. 8, 10 and 66 are apparently cases of the so-called "Albuminuria of Adolescence," or as termed by other writers "Cyclic Albuminuria." These three cases closely resemble each other, the amount of albumen being slight and variable in quantity in each. The specific gravity, color and quantity of urine passed daily closely approximates the normal. The remaining two cases can doubtless be classed among those known as functional or intermittent albuminuria. Neither manifest any other symptom of kidney disease than the occasional presence of a slight quantity of albumen in their urine.

SUGAR. Sugar was found in the urine of four of the 110 cases. This high percentage (3.6 per cent.) is largely in excess of the frequency of glycosuria among the sane. The tests used to demonstrate its presence were: Fehling's and Haines' cupric sulphate; Boettger's bismuth; and the Picric acid test.

Several manifestations of the psychically diseased readily account for the fact that diabetes is a frequent concomitant of insanity. Among the most prominent may be mentioned the following:

A. Nutrition disturbed.

Prolonged and intense mental excitement and emotional disturbance, insomnia, anorexia, the ever varying physical strain that the mentally diseased economy undergoes, causes disturbed and impoverished nutrition as well as nervous degeneration in cases which are usually of a neurotic temperament from heredity.

B. Organic cerebral disease.

The special frequency of gross cerebral disease in the psychoses. Glycosuria due to disease of the brain is often met with in hospital practice. Frerichs collected thirty cases of brain disease giving rise to the excretion of sugar in the urine. Injury or tumors of the medulla in man and animals have demonstrated that a diabetic centre exists in the medulla near the floor of the fourth ventricle. Bernard located its exact position by a few well executed experiments on animals. Recklinghausen quoted by Tuke found sugar in the urine of a case of tumor of the floor of the fourth ventricle and Dompeling, quoted by the same authority, in a case of tumor of the pons and upper third of the medulla.

C. Congestion of the nervous centres.

The great motor restlessness of the maniacal insane is thought to be due to congestion of the motor tracts of the cord and motor centres of the brain. Pavy claims that the close proximity of the Bernard's Diabetic centre in the medulla to the over-functioning motor tracts would lead to stimulation of the latter, and the appearance of sugar in the urine. Diabetes due to this cause differs from that originating in disordered nutrition by the absence of progressive emaciation, voracious appetite, intense thirst and rapid course.

Judging from the frequency, in insanity, of these three-mentioned factors in the etiology of diabetes, it would seem that Glycosuria would be a frequent concomitant of mental disorder. My analysis of 110 cases seem to show that diabetes is 50 per cent. more frequent among the insane than any other class of the population. A more extensive urinalysis is necessary before any definite statement can be made on this subject.

The mean specific gravity, of the urine, of the four cases mentioned, was 1038.5.

Briefly analysing these cases, we find them as follows :

No. 59. M. J. K., aged 50 years; Acute Mania; physical health good. Urinalysis during the mania revealed the presence of sugar in large quantity, and a specific gravity of 1048. On subsidence of the mania sugar disappeared and has not since returned. The glycosuria in this case was doubtless due to the last-mentioned cause enumerated above, namely, temporary congestion of Bernard's centre in the medulla, and tends to advance the latter theory as a common cause of transient glycosuria among the insane.

No. 98. John J. D., aged 98 years. (See case No. 98 above).

The only symptoms of diabetes in this case was the presence of sugar in the urine. His physical health was good and his body well nourished. The post-mortem clearly demonstrated that the glycosuria was of cerebral origin. The brain was found to be of average size and weight; dura was adherent to calvarium; ventricles enormously dilated and filled with fluid; the floor and sides of the fourth ventricle were infiltrated and greatly thickened; right temporo sphenoidal lobe softened and broken down; frontal lobes atrophied, especially the right, which was marked on the surface by a recent hemorrhage; medulla soft and anemic. The presence of sugar in the urine of this case was apparently due to the involvement of the diabetic centre in the infiltration of the floor of the fourth ventricle, together with the apparent degenerated condition of the medulla.

The other two cases (Nos. 119 and 120) present no special features of interest.

It will be noted by a reference to the tables that two cases (Nos. 35 and 99 in the column under sugar are marked with an interrogation point. On examining the urine of these patients for sugar with the Cupric Sulphate tests, the reaction indicated a large quantity of sugar. Boettger's bismuth and the picric acid tests failed to verify this fact, and other reducing agents were indicated as the probable cause of the reduction to cupric oxide. The presence of chloral in the urine of these patients, was suggested by the fact that they both were taking or had recently taken bromidia, which largely depends on chloral for its sedative action.

Witthaus [10] says that when taken continuously or in large doses chloral appears in the urine, and acts toward the cupric sulphate tests similarily to sugar. In fact many chemists use Fehling's solution as a test for chloral, in instances where the co-existence of sugar is negated.

PHOSPHATE IN EXCESS. An excess of earthy phosphates was found in 15.4 per cent. of all cases chronicled. These cases were so distributed throughout all varieties of insanity that few inferences can be drawn from its presence. Some writers have attempted to show the especial frequency and significance of an excess of earthy phosphates in cases of general paresis. It was present in 16.6 per cent. of my cases. This low percentage, compared with the greater frequency reported by other observers, I account for as follows: Of the six cases examined, all were in the first stages of the disease except one, and that single patient was the only one whose urine contained an excess of phosphates. Therefore I am inclined to the view that earthy phosphates do not appear in excess in general paresis until the latter stages of the disease, when decline is rapid.

URATES IN EXCESS. Urates in excess were found in 6.2 per cent. of all cases examined. The murexide test was used to demonstrate their presence. Of the seven cases containing urates, four or 52.2 per cent. were found in the manias. I can find no literature on this part of the subject, therefore no significance regarding its especial frequency in mania can be drawn until a series of cases are reported

BILE PIGMENT. Bile pigment was found in the urine of two female patients (cases Nos. 41 and 45) and its presence could not be accounted for from a physical standpoint, as both patients were in fair health at the time the examination was made. Gmelin's and Ultzmann's tests were used to demonstrate its presence.

Both patients were taking iron daily when the examinations were made, and in the absence of other causes, that fact I consider sufficient to account for its presence. To demonstrate this view, the administration of iron was temporarily discontinued in one case, and after the lapse of one week the urine again examined for bile pigment. As anticipated no bile was found on repeated examinations.

10. Manual of Chemistry, page 202.

That the iron caused an increase in the hæmoglobin of the blood and the latter a corresponding increase in the amount of bile pigment seems evident, the excess of bile pigment being eliminated with both fæces and urine.

SPECIFIC GRAVITY. The average specific gravity of the urine of the 110 cases was 1024.5, that of the females being 1023.5, while that of the males was 1025.5.

Dr. Gilmore, in the paper mentioned in another part of this article, says that urine of low specific gravity is most frequently found among the insane. My tables show that the mean specific gravity is much above the normal and varies according to the variety of insanity examined. In order that these cases may be readily studied I subjoin a table giving the average specific gravity of the urine of the several varieties of insanity.

Compared with the above, Tuke reports of the examination of the urine of 248 cases of insanity from the Bethlem Asylum. He found the mean specific gravity in cases of Mania to be 1026, of Dementia 1020, of Melancholia 1025, and of General Paresis 1021. The mean specific gravity of 248 cases examined was found to be 1025.5 while that of my series of 110 cases was 1025.6.

Rigby, quoted by Tuke, found a high specific gravity (1030) in the urine of Melancholiacs and a low specific gravity (1015) in the urine of cases of Dementia.

Thus it seems fairly demonstrated that the amount of normal and abnormal solids in the urine of the insane is over and above the total amount present in the urine of those who enjoy mental health, instead of below the normal as reported by a few observers.

SPECIFIC GRAVITY TABLE.

| | Mania. | | Melancholia. | | Consecutive Dementia. | | Senile Dementia. | | Paranoia. | | General Paresis. | | Epileptic Insanity. | | Hystero-Epilepsy. | | Totals. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M. | F. | M. | F. | M. | F. | M. | F. | M. | F. | M. | F. | M. | F. | M. | F. | | |
| Normal..... | 0 | 5 | 1 | 2 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 11 | 15 |
| Below Normal. | 1 | 1 | 2 | 5 | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 8 | 4 |
| Above Normal. | 10 | 16 | 12 | 5 | 6 | 7 | 3 | 5 | 10 | 0 | 6 | 0 | 3 | 0 | 0 | 1 | 84 | |
| Totals..... | 11 | 22 | 15 | 12 | 8 | 9 | 4 | 6 | 10 | 1 | 6 | 0 | 5 | 0 | 0 | 1 | 110 | |
| Average..... | 1027.7 | | 1022.8 | | 1024.5 | | 1027.4 | | 1019 | | 1028 | | 1026 | | 1020 | | | |

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MRS. CLANCY.—"Yis, Mrs. Muggins, Pat and Oi part to mate no more. Oi went to the hospital to ax after him. 'Oi want to see me husband,' sez Oi—'the man that got blowed up.' 'Yez can't,' sez the docther—'he's under the influoence of Ann Estheticks.' 'Oi don't know the lady,' sez Oi, mighty dignified loike; 'but if me lawful wedded husband kin act like that when he's at dith's door, Oi'll have a divorce from him!'"—*Ex.*

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SIR BENJAMIN RICHARDSON, in an address on "Athletic Life," says that abstinence from alcoholic fluid is absolutely necessary. "As long as you are in course of training, don't touch the hurtful thing. It will undermine all the qualities on which you depend for success, will injure your precision, your decision, your presence of mind and your endurance."—*Pub. Opinion.*

## SOME INTERESTING SURGICAL CASES.

MARIE B. WERNER, M. D., PHILADELPHIA, PA.

I desire to report these surgical cases and study the tumors, because they present some particularly interesting features.

CASE I.—A multiple fibroid, very readily diagnosed by the many irregular nodules, clustered around the main tumor. The patient, who was sent to me by Dr. Ella S. Webbs, of Oxford, Penn., had suffered from hemorrhages and the usual pressure symptoms, all of which made it impossible for her to work; the result of the operation was all that could be desired.

These tumors are sometimes benefited by the simple removal of the ovaries and tubes, with the hopes of depriving it of its nutrition and inducing thereby a shrinkage of the mass, as well as permature menopause. This treatment was adopted after observation had taught that natural menopause had sometimes induced a cure. In this case the ovaries were so bound down that it became necessary, in order to give the desired relief, to remove the entire mass.

The operation of hysterectomy in this special class of fibroids has two important advantages; by the removal of the entire uterus, the patient no longer is in danger of any retrograde (sarcomatous) changes which, we know, often take place in this abnormal tissue; and again where there are fibroids near the mucous surface which even after careful and complete removal of the appendages have given rise to dangerous hemorrhages and necessitating further operative procedure.

CASE II.—Gives us evidence that fibroid tumors of the hard variety may grow even after the menopause has been established.

The patient was sixty years old, had five children, no miscarriages and passed the menopause at the age of fifty-two. There was no flow for two years, when suddenly a profuse hemorrhage occurred, which was repeated in a few weeks. An examination revealed an enlarged globular uterus and a small atrophied cervix; the fundus of the uterus reached a little below midway between the pubis and umbilicus. Various medicines and treatments were used, with but partial success. The intervals between the hemorrhages were longer, but the loss of blood was more profuse; in fact, on one occasion the loss in a half hour was so great as to produce syncope. The hemorrhages came on without pain or warning. In one instance the patient was sitting on a chair and remarked that she must have sat in water, but upon looking found that a hemorrhage had suddenly come on, her clothes and the floor were stained with blood; in the recumbent position it was scarcely possible to feel her pulse for some time. This was about the last severe hemorrhage before the operation. She felt that she was getting weaker, and was beginning to feel unable to attend to her household duties as formerly.

An examination showed that the mass had grown to about twice the size it had been on a previous examination, two years before. It was wedged down in the pelvis and almost on a level with the umbilicus. After consultation with Dr. J. Price, the patient, herself, fixed upon the time of operation, which was performed in January,'93, after some time of preparatory treatment. Assisted by Dr. J. Price, I removed the tumor which was wedged down in the pelvis, adherent in some places, the ovaries and tubes, particularly the right tube, being supplied with immense blood vessels.

In making the stump, we found the cervix, as well as the whole uterine cavity, filled with a soft spongy mass, suggesting cancerous changes. Closer investigation of the tumor, after the operation was completed, revealed a very large uterine cavity, the distance between the two cornua being six inches, not including that part of the canal inclosed in the stump. The anterior wall of the uterus was thin enough to give the definite outline, externally, of the finger within the cavity, suggesting the danger of the use of intra-uterine electricity or the curette, both of which, with a solid resisting tumor in the posterior wall would have found a ready exit, after the exercise of even a moderate amount of pressure, with an unavoidable resulting peritonitis. Again a careful examination of the tumor will show you the enormous blood vessels, especially near its mucous surface, their open mouths showing the daily danger of a fatal hemorrhage. This tumor, without doubt one of the hard variety of fibroids, increased in size during

the last four years. We are taught, and various operators have agreed, that the simple fibroid ceases to grow and even decreases after the menopause has been established. We have here a case in which there is undoubted exception to the above theory.

Case III. That of a young girl aged twenty-eight, who had been suffering with hemorrhages and pain during the last two years. She submitted to various kinds of treatment, electro-puncture among the others, which latter, unfortunately, had produced some difficult adhesions. Examination showed a uterine tumor reaching midway between the pubes and umbilicus. The cicatrices from electro-punctures could be easily felt; both lateral pelvic spaces were painful on bi-manual pressure. The patient was anæmic in the extreme, her hands and finger nails waxy in color and almost transparent. The tumor as it came to sight after incision was made, had the characteristic appearance of a myoma, so much so that my assistant, Dr. Elliston J. Morris, inquired if I was absolutely certain that the patient was not pregnant. The tumor was removed with difficulty, since it had been partially twisted on its axis from left to right, and become adherent in that position, no doubt by the electro-punctures, for the scars were found on that side. With the united strength of my assistant and the screw, we were at last enabled to enucleate it. The left ovary and tube were fixed behind the uterus, while the right appendages were floating free above the pelvic brim.

This case will enable me to show you, very clearly, the formation of a pedicle, which has always been the most interesting and important part of the extra-peritoneal method. The tumor having grown rapidly, its peritoneal covering was thoroughly stretched; it became necessary, after having adjusted the wire loosely, to make a circular incision into the capsule from four to five inches above the line of the nœud. This immediately retreated close to the wire, and the bladder having been drawn up, by the rotation of the tumor, was thus saved from being injured. The operation was soon completed after making the usual toilet of the peritoneum, and taking the peritoneal stitch on each side of the stump. A drainage tube was placed, and the incision closed.

This case again shows an enlarged uterine cavity measuring four inches between the cornua. Some granulations can be seen on the mucous surface.

Case IV.—Is one of unusual interest, of uterine cancer removed through the vagina; interesting from the fact that through the patient's persistent refusal of an operation I have actually seen its devolopment. Three years ago she came to me, suffering from pelvic pain, due to pyosalpinx. I advised an operation to which she submitted, made a good recovery and would hear of no further operation, which was actually called for on the large, unilateral tear of the cervix. She occasionally appeared at my office for local treatment, usually after having had a severe hemorrhage or some pelvic pain. The uterus being freely movable, I knew the pelvic pain was not due to any adhesions. The appearance of the cervix, enlarged, congested and mottled, showed me that I could look for the trouble there. Several weeks treatment, consisting of depletion and tampons, would usually relieve her for as many months, always to be followed by a return of the former appearance and symptoms.

All suggestions of operation for any radical treatment remained unheeded. At one time I succeeded in removing a small portion of the cervical tissue and examined it carefully under the microscope. It showed distinctive cancer cells. The patient again remained deaf to all good advice and I saw nothing more of her for about six months; when she came she reported having had hemorrhages and suffering now from a constant offensive, viscid discharge. She then permitted me to remove the uterus. As you see the uterus has been entirely removed, but the cancerous degeneration seemed to have proceeded on to the right broad ligament. This operation was done October, 1892, the patient is still living, but is no doubt suffering from a cancerous degeneration of one or more of the internal organs; she has a slight inoffensive discharge from the vagina.

This case taught me that early operations will give a better chance to the patient than any other known treatment.

Case V.—Is a case of sarcomatous kidney, removed from a child two years old, August, 1892. It weighed, some hours after removal, 8 lbs. and the measurements were 8¾ by 5½ inches; cicatrix 6½ inches.

The child had the appearance of a

little skeleton straddling a tumor. The operation was done more to relieve the pressure symptoms she was suffering from, thinking she had some abdominal effusion, but it became necessary to remove the kidney after the incison was made and strange to say the child got well. There were many things against which she had to struggle. The operation was done in a four-roomed house in a small street, a railroad about a quarter of a square away with all its accompanying dust and dirt, and the thermometer in the 90's, so that I was placed in a position of choosing between two evils after the operation—to let the child remain in the hot room or to place it in the coach and set it out in the shady places on the street.

There was several interesting points about the operation; one, which necessitated peeling off the adherent bowel resulted in a tear of its mesentric attachment of about six inches in length. This was carefully sutured and a voluntary movement three days after the operation seemed to be painless and had absolutely no sign of blood, proving its union. Urination was voluntary during the first night, with but slight amount of blood present which was probably due to the cutting of the ureter. I have always regretted that I have not had a picture of the child as she was before the operation. Of course there is always a sequel to these operations. One usually looks for a return and it came in this case, although the child became apparently healthy. The return was located in five of the retro-peritoneal glands, also a growth in the pancreas similar to the one on the kidney. The right kidney was slightly enlarged otherwise it seemed normal.

As you will see, this tumor originated in the corticle substance; the pancreas was attacked in the same way. The patient died on December 13th; the return having shown itself three weeks previously.

In a collection of thirty-one nephrectomies for abnormal growths of the kidney occurring in children at or under twelve years of age, we have sixteen recoveries and fifteen deaths, making an immediate mortality of 48.4 per cent.

Of the sixteen there were eight who succumbed to a return of the disease, five at or under four months (one of these at eleven weeks), three at or under eight months. One was reported to have died one and a half years after the operation; cause not stated. In one no return after three months, another after four months, and four not stated.

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**Tuberculin as a Test for Tuberculosis in Cattle.**

Probably few physicians are aware of the enormous practical value in the animal industry of tuberculin; that is to say, if the position taken by the New York and other State Boards of Health regarding it is correct. A gentleman who has a valuable herd of thoroughbred cows writes us that twice within the last six months his herd has been examined by competent veterinarians and pronounced healthy. A third examination, however, with the aid of tuberculin, caused a condemnation of over one-half the herd. He adds:

The New York State Board of Health is killing by the hundred, animals condemned by diagnosis with tuberculin, and the State is paying full value for them. The veterinarian says that the autopsy shows the diagnosis to be correct in every case. He says also that it is impossible for the best veterinarian to discover tuberculosis by physical examination except in extreme cases. My herd is apparently in splendid condition. Breeders do not know of its existence in their herds. They let a cow remain in the herd until she is unquestionably tuberculous and then remove her, but she has then already infected the herd. A temperature of 103° F. condemns the cow. In a herd of Jerseys, at Troy, of eighty head, he has killed thirty-three, and will kill twenty more of them this week. Autopsies are held in the presence of physicians and veterinarians. There have been 15,000 tests with tuberculin in England. New York evidently believes in this kind of diagnosis, and will probably have to pay $500,000 to eradicate tuberculosis. The veterinarian says the State is full of it in herds both of thoroughbreds and common cows.

We understand from other sources that the State Board of Health fully believes in the certainty of tuberculin diagnosis. Through its means it has been discovered that some of the best bred herds, supplying high-priced milk, cream and butter, are infected.—*Med. Rec.*

## LARYNGISMUS STRIDULUS FOLLOWING BULLET WOUND IN THE ARM.

J. W. Irwin, M. D., Louisville, Ky.

A few years ago I had under my care a man twenty-two years of age, the son of a hardware merchant, who while handling a pistol one day accidentally discharged the weapon, the bullet entering his right arm just under the anterior border of the deltoid muscle near its insertion, right over the region of the nerves leading down from the axilla. No notice was taken of the bullet, or could it be found, as it was buried under the muscular surface; the external wound healed without any trouble. Four months afterward, he was taken with the most intense form of croup. It was not the season of the year when croup usually occurs. (It looked more like laryngismus stridulus.) I was sent for in the initial attack, and administered remedies with a view of relaxing the condition. Medicines did not seem to have any effect unless I kept him under the influence of chloroform—ether relaxed it even better than chloroform. I treated him several days for this affection of the throat, and I could discover nothing but a spasmodic condition to treat. He could not drink without bringing on an attack; could not change his position, could not laugh, could not talk without bringing on a most intense form of spasmodic croup or laryngismus stridulus.

I knew nothing of his former injury at this time—later he told me that he was shot in the arm some months before; I then began to look for some reflex irritation as the cause of the trouble. Upon inquiry the history as above related was elicited. I made an examination of the wound. Nothing could be seen but a very small cicatrix slightly depressed, and after lifting the muscle from the bone with my fingers, I thought I could feel a little hard substance. I asked him if the bullet had ever been removed, and he stated that the physicion who attended him had never been able to find it. That it occasioned him no trouble up to that time, and so far as he knew the bullet was still in his arm. There was no sensitiveness to call attention to the cicatrix. So far as references to the wound is concerned, the patient did not know he had a bullet in his arm. I then made a further investigation, and found the bullet which had lodged in the deltoid muscle near its insertion. It had become encapsulated, and was about the size of an hazel nut. I at once suggested the removal of the bullet, believing that it might be the cause of the reflex trouble. He accepted the proposition, and the operation was easily and quickly done. The second day after the removal of the bullet, the spasmodic trouble disappeared, and four years afterward it had not returned. I would not have been surprised in that case to have seen epilepsy.

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Teacher.—"That is the fourth question you have failed to answer. If you don't study harder, how do you expect to get along when you grow up?"

Little Boy.—"I guess I'll be a schoolteacher, an' when I want to know anything I'll just ask th' class."—*Good News.*

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So greatly are the Paris hospitals overcrowded by consumptive patients that a separate hospital has been established for their benefit at Agincourt, by the municipal authorities of Paris.—*Pub. Opinion.*

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Wife—"George, which is proper; to say 'Congress meets on Monday,' or 'Congress will meet on Monday?'"

Husband—"Nuther wun, there haint a-goan to be corum!"—*Cleveland Plain Dealer.*

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Kept the Cash in the Family.—"Well, the widow sued the editor."

"Get anything?"

"One hundred dollars. But she didn't have it long."

"Why?"

"Editor married her."—*Atlanta Constitution.*

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Professor Lombroso, the Italian scientist, concludes after investigation that women of the criminal and immoral type are invariably larger of hand and feet and smaller in the head than average women.—*Pub. Opinion.*

# TRANSLATIONS.*

## THE ROLE OF THE BLADDER DURING CHILDBIRTH; RETENTION OF URINE.

The form of the bladder in the woman differs from that in the man. Instead of being ovoid with a median distension, it is more flattened from before back and is not symmetrical; its right half is larger than its left. Its base assumes a much greater lateral distension on account of the disposition of the vagina and the pelvic organs in general. This flattening and this enlargement are more marked in the multiparous women than in the primiparæ. Haller admits that this enlargement is due to the pressure which the gravid uterus exercises upon its base. In consequence of repeated pregnancies this lateral expansion will become more and more marked. Barlow attributes this special form less to the effects of the pressure of the gravid uterus than to the movements and the rubbing which the uterus and its appendages exert upon the bladder. Ouimet believes that both causes are active. During the first months of pregnancy, the form and the connections of the bladder change but little. The sinking of the gravid uterus together with its weight, on account of its firm attachment to the posterior wall of the bladder, prevent elevation of this organ distended by urine. Its antero-posterior expansion not being permitted, in proportion as the urine accumulates the bladder can expand only in the transverse diameter. When the uterus on account of its volume is obliged to rise out of the pelvis and to take its place in the abdominal cavity still the same conditions hold; its antero-posterior expansion is always hindered by the uterus; its lateral expansion only is easy. It is at this period, also, that there is produced an alteration in the situation of the urethra. It forms normally a slight curve with its convexity below. If the distended bladder drags itself upward, the curve increases, if it forces itself downward, it diminishes or disappears. There is also a change in the curve in proportion, as the vagina is stretched during pregnancy. At the end of the pregnancy, the capacity of the bladder is, in primiparæ, diminished on account of the low situation of the inferior segment of the uterus and the fetal head, and in multiparæ, quite to the end of pregnancy, the result is similar, although much less marked on account of the sinking of the uterus. In some cases of pregnancy (pendulous abdomen) the bladder may be compressed from above downward, and consequently show a tendency to the formation of a perineal or vaginal hernia. A retention of urine exists then, and a large cystocele appears. At the beginning of labor, important changes may be observed. The urethra is lengthened, and the bladder is elevated above the pubis. This modification in the situation of the bladder is produced in order to avoid a retention of the urine. "The urinary bladder," says Smellie, "in the pregnant woman near to term, is often so pressed upon by the uterus that it can only contain a very small quantity of urine." From a study of the subject of the retention of urine, during and after child-birth, Ouimet has formulated the following conclusions:

1. Retention of the urine during confinement and delivery, may produce results so grave for the mother and child that every accoucheur called to attend to a women at the beginning of labor, should at the first disengaged moment, inquire as to the time that has elapsed since the last micturition and as to the manner in which micturition was accomplished during pregnancy.

2. The accoucheur should not be satisfied with the woman's replies, but should practice a careful examination of the genito-urinary organs.

3. A small quantity of urine retained in the bladder will suffice to cause grave disorders. The bladder should be emptied naturally or artificially, at the time of confinement.

4. If it is always proper to empty the bladder, even in normal confinements it is of the greatest importance to empty it when it is necessary to perform an obstetrical operation—version, the application of the forceps, Cæssrean section, etc. —Ouimet in *l' Union Medicale du Canada*, July, 1893.

—D.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

## A CONTRIBUTION TO THE THEORY OF EPIDEMIC NIGHT BLINDNESS.

O. Walter (*Arch. f. Augenheilkund* xxvii) observed in the Ural region, during the years 1889–92, 269 cases of night-blindness; 197 among men and 72 among women. The history of these patients was that there were no prodromal symptoms; the sight was suddenly lost on a certain evening. The disturbance in vision began in the centre of the visual field, spreading centrifugally. Shortly before or after the rise of the sun, the sight again suddenly returned. The grade of blindness in the presence of poor illumination varied in different cases.

Ophthalmoscopically there was in but few cases an appearance of dimness in the region of the papillæ. The duration of this disease was variable, and returns occured in 78.8 per cent.

In places where sanitary conditions were poor, this epidemic occurred early in the spring, and attacked persons of all ages; an increase of numbers being noticed among those who suffered from lack of good sanitation. A deficiency in nutrition could be regarded as a predisposing element, to which could be added certain direct causes. No psychical overexertion or dazzling elements, as some other authors have described, were noticed in these cases; in all miasmatic influences were present.

The treatment consisted in nutritive diet, and internally, cod-liver oil with strychnia. —W.

### Abdominal Hysterectomy.

Dr. L. G. Richelot reports (*L'Union Medicale*, 1893) twenty-one hysterectomies with two deaths. Great importance is placed upon the following points in the technique. 1st. The stump is carefully sewed with silk. 2d. A peritoneal flap having been previously prepared, is secured over the surface of the stump. 3d. The stump is carefully seared with the cautery before being covered. Total extirpation of the uterus has not yet received his approbation.—*Centralb. f. d. Med. Wiss.*, No. 45, 1893. —W.

### The Dublin Conjoint Examinations.

The returns of the October examination of the Colleges of Physicians and Surgeons in Ireland show a decrease in the number of candidates as compared with last year of 149 to 122. The examination was, on the whole, excessively fatal to candidates, the rejection percentage being 54.0 as compared with 42.2 for the same examination last year. The "mortality" was greatest in the second and third examinations, in which the rejection rates were 60.9 and 63.6 as compared with 38.1 and 58.2 for the same examinations of the same period last year.

The committee recommend to the Colleges:

(*a*) That a numerical system of marks ranging from 0 to 10 be substituted for the "judgment" system at present in use.

(*b*) That a uniform standard of 50 per cent. be the passing mark in all subjects, and in all examinations.

(*c*) That in deciding as to whether a candidate has passed in any subject or not, the marks in all the divisions of the subject—written, oral, and practical—be considered together; provided, however, that bad answering in the clinical portion shall not be compensated for by excellence in the other portions of the subject.

At the Preliminary Examinations held in November and December, the rejection percentage was 44.3, against 47.4 at the same examination last year. The entries were 89 as compared with 96 last year. There seems to be a curious variance in the quality of the candidates at the two examinations of the present year, the rejection percentage of the November examinations have been 57.7, while that of the September examination was only 38.7. On the whole it will be observed that the Irish Conjoint Examinations do not err on the side of softness. Whether it be that candidates are of inferior quality, or that the examination is unpractical and excessively severe, the fact remains that the average candidate runs a better chance of getting through his examinations in either England or Scotland than in Dublin. Neither of the other divisions of the Kingdom show so high a rejection percentage as Ireland.

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SATURDAY, JANUARY 27, 1894.

## EDITORIAL.

### REORGANIZING A COLLEGE.

The Jefferson Medical College has long sustained a reputation as one of the best medical institutions in the United States, and to-day all things considered it has no superior in this country. The men comprising its present faculty, are worthy successors of those teachers of the past whose abilities created the reputation of the college, and whose fame is inseparable from the fame of Jefferson. Such men as Parvin, Keen, Da Costa, Forbes among the older members of the faculty, are men of world-wide reputation and authority, both as teachers and practitioners. Among the younger members such names as Dercum, De Schweinitz, Hare, Montgomery have more than a local significance and assure the maintenance of its reputation at the same high level that has existed in the past and now exists; and in all probability buds of promise will be developed from among the sucklings of the faculty.

If not always the first to institute movements towards higher medical education, Jefferson has never been the last to adopt improvements. The college has a large and enthusiastic alumni association, which possesses what few such associations do possess, a considerable influence with the powers that manage its alma mater. It was probably due to the influence of this association that the college has recently adopted the four years' course of study to obtain a diploma.

At a meeting held last week, the Association adopted resolutions calling upon the Board of Trustees for further modifications in the organization of the college, which will undoubtedly increase its effectiveness. The first of these calls for the abolition of the fee system of paying the teachers and a substitution therefor, of fixed salaries. Such action would tend to equalize the compensation of the members of the faculty, and would at once cut off the greatest obstacle to enforcing a higher standard of medical education, for the question of increasing or decreasing income would have no weight in considering the fitness of an applicant for matriculation. The require-

ments for admission could immediately be strictly enforced, and if desirable, raised, and would at onee exclude a class of aspiring novitiates, whose presence in an institution of learning can be accounted for only on the supposition that they can pay admission prices. This would at once conserve the reputation of the institution for the quality of its product and for the quantity of its honesty.

A second resolution was adopted, requesting the Board of Trustees to appoint a member of the faculty as prevost, and place in his hands certain high powers and privileges, as for instance, meeting with the trustees, recommending additions, etc., suggesting candidates to fill vacancies. In general, to be an authoritative working-head for this institution, with the extensive powers committed to similar officials in other institutions that we wot well of. The appointment of such an official is fraught with danger to the ultimate success of the institution, even when limiting the power placed in his hands. While placing unlimited power in any one person's hands is practical suicide or slavery. History need not be searched for examples to prove this statement. Nor are the causes of disaster hidden from view. The centralization of power is of benefit up to the point where it places definitely responsibility for the exercise of powers, but when carried to an extent that makes power autocratic, responsibility practically ceases and the exercise of power implies slavery on the part of all coming within its province.

Of course it will be claimed no such absurd proposition has been made, and that there is no intention to establish a dictatorship. Neither did the fabled tailor intend to admit the entire camel when he allowed him to put his nose in the door. The advantages of a working head for an institution are obvious, but the disadvantages of that head becomimg swelled are sufficiently great to deserve consideration. If great power is to be entrusted to any one person, he must be possessed of certain characteristics to perform the duties required of him. His individuality must be decided enough to enable him to formulate a definite policy. His executive ability must be great enough to successfully carry out his policy. He must combine the wisdom of the serpent with the harmlessness of the dove. He must be all things to all men. He will receive the support of the authorities that established his position—at least he will receive it at the outset, later on he will compel it. The greater his ability to fill the position, the greater danger is he to the final success of the institution.

Among the eminent men constituting the faculty of Jefferson College, we doubt there is one who, placed in such a position, could command the hearty support of his peers in the faculty. Dissensions invariably arise among men seeking the same end, but thinking for themselves. Where the will of the one is paramount, obstacles to his policy must be removed, and opponents retire, or suffer the infliction of an emeritus position. Policy will not allow a recurrence of like opposition if preventable, and the dictator installs a puppet of his own in the vacant position. The dictator's position is thus strengthened at the direct expense of the institution. Retirement is the fate of every man who presumes to think for himself and has the courage of his convictions.

A medical college in pantomime, whose puppets dance at the bidding of any one person, is a sorrowful spectacle for the last decade of the Nineteenth century.

A one-man medical college is always a 'one-horse' institution.

THE REPORTER is interested in this matter in as far as the cause of medical education in Philadelphia is concerned, and it begs to commend to its Jefferson friends that saying of Demosthenes: "The end of wisdom is consultation and deliberation.

## THE MEDICAL BUCCANEER.

Before the days of steam-ships, and indeed until the early part of the present century, the high seas were everywhere infested by bands of pirates in quest of prey.

When they sighted a prize they set sail straight for it, and when the attack was ordered no quarter was asked and none given.

Those daring characters have always been painted by historians in the blackest colors. But after all, they were not without a redeeming trait, for, when captured they expected no mercy. They were a thousand times more manly than the modern, *medical* buccaneer.

To talk of amending codes, or instituting reforms, or improving the status of the profession while this insatiable gormand is allowed unfettered liberty is a travesty on reason. He plays his part in manifold ways. He often roams in high places, and may even wear a professor's gown. He looms up at medical conventions and indeed, may even be an author of no mean position. He is always clamoring for reform; he wants to reform the code, let down the bars and clear the way so that his pilfering career may be unhampered. His neighbor stands in mortal terror of him, because, he well knows, that should he be required to call him in consultation, the new arrival would quickly oust him and cooly take possession himself. He performs impossible operations and always cures every case, and the unsuspecting, simple-minded, honest plodder, as he reads his statistics, is quite overcome with amazement and admiration. He has a sneaking way of advertising. To go into the regular column of the quacks, would be to mix with the common herd; moreover it is highly expensive; therefore he has himself *interviewed*, or one of his helpers will see to it that, while the great man speaks, full stenographic notes are taken and the thing, highly colored, will be spread broad-cast in the early morning press.

The drag-net of the pirate is so far spread out, that he leaves almost nothing for the honest plodder. From year to year he becomes more and more bold, and finally, having duped and bulldozed his professional brethren, he turns his attention to lay people before whom his hideous hypocrisy is supported by consummate strategy. He wants to raise funds for a ward "for the poor, you know," run *soirees*, parties, etc., until a necessary sum is wrung out of the pockets of the unsuspecting. Then he suddenly blooms out a specialist, and now that he is safely entrenched behind his own walls, in his zeal for patients his audacity is villianous, for through the mails, he is a constant intruder, incessantly appealing to practitioners to send to him that which they themselves depend upon for their living.

Let every independent, self-respecting member of the profession rise and stamp out this scorpion. He is the bane, the curse and blight of a profession, which without him has a career of usefulness and prosperity before it.

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### The Effect of Urine, Normal and Pathological, on the Heart.

Lusini (*Arch. di Farmacol. e Terap.* Fasc 19, 20, 21, 1893) has studied the effects of normal urine when applied direct to the heart of the frog or toad, comparing it with that produced by the urine of jaundice, tuberculosis, nephritis, scarlatina, measles, and pneumonia. He concludes as follows: (1) Normal urine always causes an increase in the extent of the individual heart beats. (2) The urine passed in disease produces peculiar toxic effects directly proportional to the increase of urea, salts, colouring matter, extractives, etc., as well as to the abnormal matters contained in such urine. (3) The urine of infective disease is far more toxic than that of other common maladies; this appears to be due to the amount of leucomaines found in such urines.—*Ex.*

# ABSTRACTS.

## RUBIDIUM IODIDE IN SKIN DISEASE.

Dr. Leo Leistikow, of Hamburg, who at the suggestion of Unna, made trials with rubidium iodide at his clinic, reports (*Monat. f. prac. Dermat.* Vol. xvii, No. 10) as follows:

In all cases a five per cent. aqueous solution of rubidium iodide was used, three tablespoonfuls of which were given daily.

Case 1:—Mrs. S., aged 45 years, suffers from two specific ulcers of the hard palate. The ulcers were first cauterized with a ten per cent. solution of chromic acid for three days. After this rubidium iodide was administered internally. Under this treatment the ulcers healed completely in two weeks.

Case 2:—Mr. M., aged 30 years, has a gumma which is located in the *sulcus retroglandularis*. Restoration takes place by external application of a gutta-percha plaster mull containing mercury and carbolic acid, and with a 3 weeks' internal treatment of rubidium iodide.

Case 3:—Mrs. A. I., aged 55 years, is affected with an extensive ulcerating syphilide of the right lower thigh, accompanied by varices of the veins. The treatment consists of bandaging the leg with zinc oxide-ichthyolglue, and prescribing rubidium iodide internally. Restoration results within 14 days.

Case 4:—Mrs. A. H., aged 40 years, suffers from gummatous periostitis of the frontal bone, and besides presents an insufficiency of the bicuspid valve. Rubidium iodide effects a cure within two weeks without influencing the action of the heart.

Case 5:—Mr. R., aged 20 years, shows the first general symptoms of secondary lues; besides specific angina and universal papulous syphilides, extremely violent headaches prevailed. An eight days' inunction-treatment makes the secondary eruptions disappear, but without relieving the headache. Internal treatment with rubidium iodide in double doses for three days caused the headache to disappear entirely.

Case 6:—Mr. M., aged 30 years, who is suffering from secondary syphilis, had just undergone an inunction-treatment and desires to take iodine. He is given rubidium iodide for two days, but owing to violent conjunctival catarrh, this remedy had to be discontinued.

Case 7:—Mr. J., aged 41 years, is afflicted with acute polyarthritis of gonorrhoic origin. By a two weeks' treatment with rubidium iodide he is entirely cured. Appearance of a iododerma pustulosum.

Case 8:—Mr. M., aged 60 years, presents a gumma of the tongue. At first potassium iodide is administered and effects considerable shrinkage, but after eight days produces a violent catarrh of the upper respiratory tract. Potassium iodide is therefore discontinued and substituted by rubidium iodide. This change of treatment causes the symptoms of catarrh to diminish, and after four weeks' use of the rubidium iodide the gumma is healed.

It is especially important to note, that in the one case of syphilis complicated with valvular disease, the heart's action was not in the least influenced by the rubidium iodide. Altogether the rubidium salts have no toxic effect upon the heart like the potassium salts. It is advisable, therefore, to employ rubidium iodide in all cases where the use of potassium iodide is contra-indicated on account of its dangerous effect upon the heart. The symptoms of iodism (the iododerma and the catarrh of the mucous membranes) are not excluded by the use of rubidium iodide. On the other hand, whenever iodism follows the use of Iodide Potassium, these unpleasant accompanying effects may be avoided by the employment of rubidium iodide. Gastric disturbances were never observed. The taste of the rubidium salt is not as disagreeable as that of potassium iodide.

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PROFESSOR GARNER has returned from Africa and declares that he has learned, beyond doubt, that there is a monkey language, and it can be learned by man.—*Pub. Opinion.*

## CONTRIBUTORY NEGLIGENCE OF PATIENT AS DEFENSE TO CHARGE OF MALPRACTICE.

One of the most interesting decisions rendered for some time in a malpractice case, is that of the Appellate Court of Indiana in Young v. Mason (decided November 22, 1893, and just reported, 35 Northeastern Reporter 521). In this case the jury returned a general verdict for $1,000 in favor of the party claiming injury, and also returned answers to forty interrogatories submitted on behalf of the physician sued. Now answers to interrogatories override a general verdict when both cannot stand together, but not where they can be reconciled.

It was clearly shown by the answers in this case that the physician possessed fair and ordinary knowledge and skill, also that the manner in which he dressed and treated the injuries of this patient was, with one exception, such as is approved and followed by the most skilful surgeons in that vicinity, and which is approved by the standard authors and text writers upon the subject of surgery. The exception was that the answers did not conclusively show that he exercised due skill and care in reducing a fracture near the wrist joint. This act, with other acts of alleged negligence, it was charged caused a certain stiffness of joints and a loss of the use of the arm, for which damages were sought. But the answers also showed that the patient took her injured arm out of the sling, contrary to directions, and placed it on her lap, window sill and table, and that she also refused to allow the physician to use passive motions at the times, and to the proper extent.

Indulging every reasonable presumption and intendment in favor of the general verdict, and granting that the party who brought the action established to the satisfaction of the jury every fact put in issue, except when the answers to the interrogatories affirmatively and conclusively shown to the contrary, and giving a fair and reasonable construction to the facts, which were clearly, specifically, and without conflict or contradiction found in the answers, the court concludes that the negligence of the physician in failing to reduce the fracture near the wrist, and the refusal of his patient to allow him to subject the injured joints, at the proper times, to passive motion, concurring in producing the injuries for which recovery was sought.

The authority of other courts is quoted to the effect that "the law has no scales to determine in such cases whose wrong doing weighed most in the compound that occasioned the mischief." "It is the duty of the patient to submit to the treatment prescribed, and to follow the directions given, provided they be such as a physician of ordinary skill would adopt or sanction . . . A person cannot recover from another for consequences attributable in part to his own wrong."

The law on this very important subject is further illustrated and summed up, by the Appellate Court, as follows: Suppose a man fractures the bones in his leg below the knee, and calls a surgeon to treat the injuries, and the surgeon negligently fails to properly reduce one of the fractures, but in all other respects gives proper treatment, and the patient, in disobedience of the directions of the surgeon, negligently removes the bandages used as a part of the proper treatment by the surgeon, or is otherwise guilty of contributory negligence, and such combined negligence of the surgeon and patient unite in producing a shortness and stiffness of the leg, for which injuries an action is brought against the surgeon, can the patient recover? The patient is certainly not responsible in such case for the original negligence of the surgeon in failing to properly reduce the fracture, but this negligence of the surgeon unites with the subsequent contributory negligence of the patient in causing the shortness and stiffness of the leg. Now it seems clear, under such circumstances, and the authorities cited, that the patient can not recover for the consequent shortness and stiffness of the leg.

Where both the surgeon and patient are free from negligence, or where the surgeon is free from fault and the patient is guilty of negligence, no recovery can be had against the surgeon in any case. It is only where the surgeon is guilty of negligence and the patient is without negligence on his part contributing in any degree to such injuries that the patient can recover damages of the surgeon,—*Jour. Amer. Med. Ass.*

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*Meeting, November 7, 1893.*

### ALOPECIA AREATA.

DR. I. N. BLOOM: No. 1—This patient, a young man about twenty years of age, as you will see is suffering from alopecia areata. The feature of greatest interest in the case is the extent of the disease. I think it is safe to say that at least one-half of the hair is gone. He is a young man of exemplary habits, no suspicion even of specific trouble. He has been under my treatment for only a short time, but there is already considerable improvement. I believe in about four to eight weeks the hair will cease to fall out and the new pigmented hairs will appear. Lanugo hairs can be seen in spots, and here and there on the older patches pigmented hairs show up.

I have a lady under treatment at the present time where the disease is about one-half as great in extent as in the case before us.

### EXTENSIVE CASE OF PSORIASIS.

No. 2—This is a plain case of psoriasis, the most extensive, I think, that I have ever seen in private practice. The surface of the entire body is affected, the spots varying from the smallest patch to the size of your two palms. It is because of the unusual extent rather than the unusual disease that I exhibit the patient. He has been under my treatment about a week, and this is the second attack in which I have seen him. The first attack was about two years ago. The treatment has been simply tar; I have also given him iodide of potassium, following out the line of treatment of Chopp and Kotzen, who claim to have gotten good results from large doses of iodide potassium in these cases. He takes thirty-five drops, containing 30 grains of iodide, at a dose three times daily. As a local application I have used 10 to 20 per cent. ointment of oleum rusci. Arsenic is recommended, but this is the slowest method of treatment; it would require about twenty weeks in a case like this. Under iodide of potassium and tar I believe a cure can be effected in six to ten weeks. The extent of surface affected in this case makes me chary of using chrysasobin. Investigations embracing several hundred cases prove that iodide of potassium has absolutely no ill effect on the blood; that it does not increase or diminish the red blood corpuscles. In this connection I wish to say that I have administered in a case of brain syphilis what I believe to be the largest dose of iodide of potassium ever given in Louisville—540 grains daily. All symptoms disappeared in six weeks.

### DISCUSSION.

DR. A. M. VANCE: I remember a case of alopecia I saw when a student where there was absolutely no hair upon the head. It was in the clinic of Dr. Lunsford Yandell at the University. The patient was a boy ten years of age, whose head was as clean as a billiard ball, except the very fine hair that Dr. Bloom speaks of which could be seen only upon the closest inspection. I remember the treatment, particularly how successful it was—at each sitting an area of probably about two inches square was painted with pure carbolic acid and before over one-half of the extent of the scalp had been gone over, the hair began to grow upon the portion that had been first painted. The ultimate result in this case was perfect. The effect when the hair commenced to grow was very noticeable, as it was black.

DR. W. O. ROBERTS: The case of alopecia shown by Dr. Bloom recalls one which a number of the members of this society have seen. His scalp looks very much like the case before us. The patient has been under the care of many doctors, myself included, and among other things used in the case has been carbolic acid, but I could see no benefit from anything that was done for him. I lost sight of the patient for a number of years and a few days ago met him on the street; his head looks now about the same as it did the last time I saw him.

The other case shown by Dr. Bloom is of great interest to me; it is the most beautifully marked case that I ever saw. The patient has post-cervical enlargements, and this leads me to ask Dr. Bloom if he has ever had syphilis.

DR. A. M. VANCE: The so-called psoriasis due to syphilis is not often as extensive as this. I would like to ask Dr. Bloom if he simply takes the history of the case, or are there other ways of differentiation.

DR. I. N. BLOOM: You do not need any history at all in these cases. As this patient appears to-night it is scarcely a fair case: He has been under treatment for a week and the appearance of the spots has changed very materially. Had you seen the patient a week ago when he applied to me for treatment, with the characteristic silvery scales all over his body, you would have made diagnosis of psoriasis without any possible difficulty. As I have already stated two years ago I cured this patient of a similar attack of psoriasis, at that time the spots were only about one-fifth as abundant as now, varying in size from your thumb nail to a silver dollar. There is no syphilitic psoriasis that resembles any other psoriasis, except the so-called psoriasis palmaris syphilitica. In making the diagnosis between the three palm dis-

eases, syphilis, psoriasis and eczema, it is sometimes very difficult and you may have to take the history into consideration. But, generally speaking, a close examination of the eruption on the body will generally suffice. In the previous attack which the patient had, he was treated locally with chrysasobin and the effect was all that could be desired. At that time he received nothing internally.

DR. T. P. SATTERWHITE: Is there any eruption on the hands of the patient?

DR. I. N. BLOOM: No, nor is there any on his feet.

DR. T. P. SATTERWHITE: Is it not a fact that attacks of this character are almost always considered the result of syphilitic involvment?

DR. I. N. BLOOM: No, sir, never.

DR. T. P. SATTERWHITE: Is there any connection between this trouble and gout?

DR. I. N. BLOOM: No, sir.

DR. A. M. VANCE: What is the supposed etiology?

DR. I. N. BLOOM: It is not known. All we know about it is that in the vast majority of cases it occurs before or about the time of puberty. That at times heredity seems to play a part. I am accustomed to say to my patients that I can cure them of the eruption in from four to eight weeks, depending upon the extent of the disease but it may return in six weeks, six months or six years, or never. I have patients who have not had a return of the trouble for thirteen years; in others it has returned in a year; some in six months; in the case reported it has been two years, I prepared him for this, however; my prognosis is very conservative in all such cases. It is a very common disease, but is rarely found as wide in extent as this case shows.

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MALIGNANT DISEASE OF THE RECTUM.

DR. W. O. ROBERTS: I had a patient come here to-night with view of showing him before the society, but the gentleman whom I wished especially to see the case is not present, therefore I will not introduce the patient. I believe it to be a case of malignant disease of the rectum. I wanted to show it because of the fact that it is the third case that has come under my observation in which the disease is not advanced too far for operative interference. All of the other cases which have come under my observation have gone too far for any operation to be considered. The rule is if the cancerous growth extends higher up than you can reach with the finger, it is beyond all operation looking toward a cure of the disease. This trouble is located in the lower end of the rectum and confined to the posterior wall; an ulcerated surface which does not seem to cover a space larger than a nickel. Above and to either side of the ulcerated surface two nodules can be plainly felt. The man complains of pain in defecation and for a short time afterward, and passes mucous, pus and blood, as he describes it, with each stool. I saw him for the first time to-day; I feel satisfied that it is an epithelioma and a very favorable one for removal.

I recall to mind now a case of cancer of the rectum in a lady whom I saw soon after the trouble began. This is one of the cases where I thought operation would be followed by good results. Dr. Mathews also saw the case in consultation and concurred in my diagnosis. This patient was operated upon in St. Louis, some ten years ago and she seems to be in perfect health now.

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DR. L. S. MCMURTRY: I have here a group of specimens which I have selected from a series of abdominal sections done within the last few weeks which may be of interest.

HYDROSALPINX.

No. 1.—This is a tumor of the broad ligament, an accumulation of serum in the Fallopian tube. It was very difficult to remove without rupture on account of adhesions. The Fallopian tube you will see is distended with serum, and the ovary is in the broad ligament and not incorporated with the cyst. The fimbriated extremity of the tube you will observe is sealed upon one end of the cyst, and the other end is included in the ligature placed there. It is a hydro-salpinx. The specimen is interesting in its relations to sterility.

TUBO-OVARIAN DISEASE OF LONG STANDING.

No. 2.—Here are two specimens from the same patient of tubo-ovarian disease of long standing. The patient had suffered repeated attacks of peritonitis, and had been an invalid for several years. The ovary and Fallopian tube are so amalgamated as to appear as one mass. On cutting into this mass, after removal, a cavity containing a dark soft material is found, which would doubtless have advanced to abscess.

CYSTIC OVARY.

No. 3.—This is another specimen of tubo-ovarian disease. The operation was done yesterday morning and the specimen is quite fresh. It is a case of cystic ovary with adhesions and involvement of the adjacent Fallopian tube. The disease was bilateral, and illustrates a very severe lesion which is comparatively rare in pelvic inflammatory disease. The cyst contained a dirty, bloody fluid, consisting of decomposed blood and serum. These blood cysts are among the most dangerous of this class of tumors, and are associated with extensive inflammatory lesions. The adhesions were universal.

SUPPURATING DERMOID CYST OF OVARY WITH TWISTED PEDICLE.

No. 4.—This specimen is a very typical il-

lustration of dermoid cyst of the ovary. For some time preceding the operation the patient suffered intensely with active inflammatory symptoms, as you will see the cyst was suppurating. You will observe that the pedicle was twice twisted and is very small. The tumor was very generally attached by adhesions to the intestine and parietal peritoneum. On opening the tumor it is found to contain sebaceous matter, hair, and other material characteristic of these tumors. The surface of the sac is very dark, the result of low vitality from interference with the circulation through the pedicle in consequence of the twisting. These tumors require the utmost care in their removal, as the foul contents of the tumor must be carefully prevented from obtaining contact with the peritoneum.

FIBROID TUMOR OF THE UTERUS.

No. 5.—This is a specimen of fibroid tumor of the uterus. I have had the patient under observation at times for several years. Four years ago it was very small and was producing considerable hemorrhage. At that time I opened the abdomen and removed the uterine appendages, hoping to obtain the same good result from this operation that I have witnessed in a large number of similar cases. The patient was much improved for a time, but the tumor steadily grew and inflicted upon her much pain and distress. She was a frail woman, and in consequence of pain and hemorrhage her health was much impaired. Nervous and other complications came on in time and she was sent from home by her family physician for general treatment, with the hope of improving her general health and relieving the nervous disturbances which were of most serious character. I had not seen the patient to examine her for over two years when I was asked to see her two weeks ago, and found the tumor to have reached these extensive proportions.

Her physician had for some time advocated an operation for entire removal of the growth, and the patient was anxious for anything which promised relief. Her health had failed rapidly of late months, and her sufferings were intense. Several severe attacks of peritonitis during the past year had added to her distress. Her complexion was very bad, her general nutrition impaired, and her sufferings had made her dependent upon daily doses of morphia. The operation was the most difficult of the kind that I have ever undertaken. The tumor was firmly packed and fixed by organized adhesions to every portion of the pelvis. I had literally to dissect it out. The bladder was dissected off of the tumor in front, the rectum was released behind, the utmost care was required to protect the ureters; and the difficulties were increased by a cystic degeneration and suppuration of one portion of the tumor. The operation was completed very satisfactorily at last, and the patient was put to bed in very fair condition considering her extremely feeble condition. On examining the specimen the suppurating portion will be observed. Members of the Society will recall a number of large tumors of this kind that I have presented here from time to time, several of them much larger than this one, but in comparison their removal was easy. The patient never fully reacted from the operation and succumbed two days later.

In all the other cases here illustrated recovery was easy and prompt. Indeed in no one of them did any untoward symptoms arise.

DISCUSSION.

DR. W. H. WATHEN: I wish to say a word concerning two of the specimens exhibited by Dr. McMurtry: The specimen exhibited as a hydro-salpinx is a typical small parovarian cyst. The tube is pervious and healthy, and the cyst is below it.

The dermoid cyst is a pretty specimen of one of the varieties of dermoid conditions that are often met with in practice. No one can tell positively that a tumor is dermoid until it is removed and the specimen examined. I have removed dermoid tumors looking exactly like an ordinary ovarian cystoma, but upon critical examination discovered only a bunch of hair to demonstrate the dermoid origin.

DR. W. O. ROBERTS: In regard to the hydrosalpinx: Several weeks ago I operated upon a young girl fifteen years of age for radical cure of an irreducible inguinal hernia, left side. Upon opening the sac I found the ovary with a hydrosalpinx. As the ovary was found to be in an unhealthy condition, I removed it, together with the tube. The tumor had existed ever since the patient was quite a young child and she wore a truss strange to say, but always had to take the truss off during menstruation, and her sufferings were so intense during that time that she had to go to bed for at least two days. She has menstruated once since the operation with scarcely any pain at all, and her recovery has been uneventful.

DR. T. P. SATTERWHITE: With reference to the fibroid tumor, I want to report one case showing the tenacity of life and one of the complications of operations for the removal of growths of this character. Some years ago I assisted Dr. McCoy of Jeffersonville, Ind., in removing some fibroids from the uterus of a patient; the largest one was about the size of an orange, with three or four smaller ones. I was asked to see the patient again in the course of a month, and the abdomen was enormously distended, inflammation had set up; upon reopening the abdomen we drew off it seemed to me a gallon of pus—the abdomen was divided by adhe-

sions and the pus had accumulated above. Notwithstanding this, the patient lived over a month and then died. I do not remember how many days she lived after the inflammation and formation of pus. The operation was laparotomy.

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Dr. Cheatham read a paper on

CHRONIC RETRO-BULBAR NEURITIS.

(See page 90 in last week's issue.)

DISCUSSION

DR. T. C. EVANS: Tobacco and alcoholic amblyopia afford a striking instance in which the clinician anticipates the work of the pathologist. Von Graffe in 1866 and Leber in 1869 called attention to the pallor of the temporal half of the optic disc; this in conjunction with the central section led them to conjecture that the amblyopia was the result of a retro-bulbar neuritis. This opinion was confirmed pathologically by Samelsohn and others in 1880 and 1882. They found the pathological condition to be an interstitial sclerosing inflammation—in many respects similar to hepatic cirrhosis. The process involves the pappillo-macular group of fibers and may occur at any point from the nerve head to the chiasm. A few years ago Dr. Uthoff, of Berlin, examined ophthalmoscopically one thousand inebriates in the various asylums—he found the white sector of the disc in 14 per cent. of the cases, a much larger proportion than had hitherto been supposed. I think it not unlikely that similar sclerosis occur in other parts of the nervous system. Most of the cases occurs in those addicted to both alcohol and tobacco. In those using only tobacco the smokers are the ones usually affected.

A case recently came under my observation where the man did not smoke and did not chew excessively, yet he seemed to have a typical case of tobacco amblyopia. His vision when he came to me was reduced to 20 cc.—I advised him to leave off tobacco entirely and put him on strychnia and phosphorus; in a few months his vision came up to 20 xx.

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DISPLACEMENT OF SEMI-LUNAR CARTILAGE BY INJURY—REMOVAL—RECOVERY.

DR. A. M. VANCE: A young man, a footballist, consulted me some time ago with the history that about a year ago while playing football and making a "stand," I believe they call it, sustained an injury to his knee, "put his knee out of joint," as he called it. He said that it was pulled back and he went on with the game. A number of times he had the same accident, and every time applied the same remedy. Three or four months before he consulted me he began to suffer with pain of a boring character over the head of the fibula, with tumefaction. A week after I first saw him the pain and swelling had increased, and I then thought I could detect an abscess of the cold variety, and incised it. I found the contents to be not only fluid, but considerable caseous material also came out. The cavity of the abscess was thoroughly irrigated, but the pain continued and there was not the improvement I had hoped for. I then increased the size of the incision and removed what I took to be a floating cartilage from the knee joint. Entire recovery soon took place. I feel sure that the body removed was the semi-lunar cartilage.

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DISPLACEMENT OF SEMI-LUNAR CARTILAGE BY INJURY—REPLACEMENT BY PRESSURE.

DR. W. O. ROBERTS: Several weeks ago I saw a young man who had his knee injured in a game of football. He claimed that a man in the process of the game had struck him on the inner side of the leg between the knee and the ankle, and at the same time another one hit him on the outer side of the thigh, twisting his leg out at the knee-joint. He says it was replaced and he was taken home; while on the way there it was again knocked out and again replaced. I saw him twenty-four hours after receipt of the injury and the knee was enormously swollen, but as well as I could make out the bones seemed to be in perfect position. The leg was put up in plaster dressing which was not disturbed for ten days; when the plaster was removed the swelling had disappeared, and on the outer side of the joint there was quite a protuberance which I thought at first was the result of lateral displacement of the knee, but upon careful examination and measurement became satisfied that it was not, but that it was one of the semi-lunar cartilages displaced. Under chloroform by extension of the leg, and pressure upon the protruded cartilage much to my surprise it slipped in. I feel satisfied in this case that it was one of the semi-lunar cartilages. The plaster dressing is still on, and I am a little inclined to believe there will possibly be a recurrence of the trouble upon the slightest twisting of the knee.

IODIDE POTASSIUM IN CEREBRAL SYPHILIS.

DR. I. N. BLOOM: I had supposed that a a few months ago in speaking of the use of iodide of potassium in cerebral syphilis, I had given the largest dose ever administered in Louisville—540 grains per day. It seems that Dr. Roberts has given a larger amount, and I would like to have him tell us something about the case.

DR. W. O. ROBERTS: The case has already been reported. It was a case of brain syphilis which I saw with Dr. Bodine. Iodide of potassium was administered in gradually increasing doses until the patient received one-half ounce three times per day, a total of 720 grains daily.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE AMERICAN JOURNAL OF OBSTETRICS for January contains a paper by Dr. Howard A. Kelly on

**The Direct Examination of the Female Bladder with Elevated Pelvis—The Catheterization of the Ureters under Direct Inspection, with and without Elevation of the Pelvis.**

After reviewing the results obtained by others in this field, the author describes his own method by which, he states, any gynecologist, after a little practice, should be able in almost every case to catheterize either ureter within a few seconds after the introduction of the speculum. The following list of instruments and accessories is given by the author as required for the examination: female catheter; a series of urethral dilators; a series of specula with obturators; common head mirror and lamp, Argand burner or electric light; long, delicate mouse-toothed forceps; suction apparatus for completely emptying the bladder; ureteral searcher; ureteral catheter without a handle; several bran bags or an inclined plane for elevating the pelvis. A valuable aid for the beginner searching for the ureteral orifice is the following: A point is marked on the cystoscope five and a half centimetres from the vesical end, and from this point two diverging lines are drawn toward the handle with an angle of sixty degrees between them. The speculum is introduced up to the point of the V, and turned to the right or left until one side of the V is in a line with the axis of the body; then by elevating the endoscope until it touches the floor of the bladder the ureteral orifice will usually be found within the area covered by the orifice of the speculum. The ureteral orifice can often be found by an adept at once, and almost instinctively, by a single movement of the speculum after its introduction into the bladder. The author states that an anesthetic is not necessary for cystoscopy or catheterization of the ureters, unless the urethra is to be dilated up to No. 14, 15, or 16. In nervous women it is often best to make a thorough examination first under anesthesia. Subsequently a satisfactory illumination of the bladder can be made and the ureters catheterized and any ordinary treatment applied through the number ten speculum without anesthesia. A pledget of cotton saturated with a five per cent. cocaine solution, inserted into the urethra seven minutes beforehand, greatly facilitates the dilatation and is often the best form of anesthesia. The author believes it is the duty of the surgeon to examine at once all bladder affections which are more than trifling, to disclose at the exact nature and extent of the disease. The procedure is also of use in defining the ureters in hysterectomy for carcinoma and in some hysteromyomectomies. The paper is illustrated by cuts of the instruments and photographs showing the method of applying them. The article is an amplification of a former paper by the author entitled "My Recent Ureteral Work," published in *The Annals of Gynæcology and Pædiatry* for May, 1893, and reviewed in the issue of THE MEDICAL AND SURGICAL REPORTER for May 27, 1893.

Dr. Philander A. Harris contributes a paper on

**A Method of Performing Rapid Manual Dilatation of the Os Uteri, and its Advantages in the Treatment of Placenta Previa.**

The author believes that the employment of rapid manual dilatation must be restricted to cases of advanced pregnancy where, for any reason, it is desired to effect prompt delivery. Its use presupposes the possibility of the full introduction of the index finger to its largest diameter without much delay or difficulty. If with the patient anesthetized, the index finger cannot in a very few minutes be fully introduced, he would seriously doubt the possibility of successful employment of this or any other manual method of dilatation, and would advise the operator, for the time at least, to cease further attempt. The author's experience with his particular method is limited to seven cases of placenta previa, six cases of crossed birth, and two of eclampsia. The method advised by the author is as follows: The index finger is introduced up to its largest diameter with the os. If the forefinger be now withdrawn till only the tip engages, it will generally be found that the tip of the thumb may be introduced alongside the finger. When the tips of both index finger and thumb are thus within the ring, and the second finger sharply flexed, with the os resting on its palmar and outer aspect, we have but to keep the index and second fingers close together to form a notch from which the os-uterine ring cannot easily escape. This the author terms the first position. The straightened and extended thumb, resting on the outer lateral side of the index finger, is now carried as far from the tip of the index finger as the enlargement of the os will permit. Considerable power for dilatation may indeed be exerted by continuing this movement of the thumb, but a far greater and far less fatiguing force may be exerted if we implant and immovably hold the thumb on the index finger whilst forcibly and together flexing the index and second fingers. When a little headway has thus been gained, we slightly extend the index and second fingers, which will permit the thumb to travel further from the tip of the index finger, at which point we again press and hold the extended thumb firmly against the outer side of the index finger. In this position the holding point is again taken, whilst tonic flexion of the index and second fingers continues the work of dilatation. After a while the fingers are again slightly extended, which will permit the

thumb to be carried still further toward the metacarpo-phalangeal articulation. Whilst holding it firmly on the index finger, flexion of the index and second fingers should be renewed. If tonic flexion of the fingers has been steadily maintained, we shall now be able to introduce the index and second fingers and thumb. The relation of the extended thumb to the first finger is maintained as before, while the os, encircling the thumb and also the two fingers, rests on the dorsal surface of the more sharply flexed third finger, in the same manner as it rested on the second finger before. The power for stretching is derived from fixation of the thumb on the first finger while counter-pressure is effected by flexing the index, second, and the third fingers. In a short time we shall have dilated sufficiently to permit the introduction of the third finger. The os, still hooked over the tip of the extended thumb, will now have its point of counter-pressure between the third finger and the inner latero-dorsal aspect of the fourth finger. Tonic flexion of all the fingers is again resorted to, and the gain taken up by occasional slight extension of the fingers and movement of the extended thumb toward the metacarpo-phalangeal articulation. Gradually, in this manner, the thumb and all four fingers are introduced. Here again the enlargement is effected by flexion of all the fingers, although the index and second will be flexed far less than the third and fourth fingers. This, the author terms, the fourth position, and states that the limit of dilatation in this position for a hand measuring seven and three-quarter inches over the metacarpo-phalangeal articulation (as measured for gloves) is eight and a half inches (circumferential measurement). The extreme limit of possible and easy dilatation with the hand in this position will not exceed the glove measurement more than one inch, which is scarcely sufficient for the easy introduction of the whole hand. He then resorts to what he terms the fifth position, in which the os is made to encircle the first row of phalangeal bones of the fingers, and the second or last phalanx of the thumb. The movement required in this posision is extension of all the fingers, the tips of the fingers being at the same time flexed to lessen their encroachment on the intra-uterine space. A less fatiguing and somewhat more powerful dilating manipulation (which the author terms the sixth position is effected by causing the os to encircle the second row of phalangeal bones of the fingers and the first phalanx of the thumb. In either of the last two positions the degree of circumferential dilatation possible will exceed the above glove measurement by at least three inches. This, of course, is a much higher enlargement than is required for the introduction of the hand into the uterus. The author states that there is neither call for dragging down, or pushing upward of the os; it is dilated *in situ*, while the encroachment on the intra-uterine space is reduced to a minimum by flexure of the tips of the fingers in all the stages of every position. Any normal hand, he thinks, should endure the fatigue consequent on the accomplishment of rapid dilatation, if dilatation is possible. Having once failed to accomplish rapid dilatation, owing to the impossibility of introducing the first finger, the author reminds his readers that it may not be possible to effect dilatation by this method. Appended to the paper is the report of cases in which the author made use of his method. The paper is illustrated by cuts showing the position of the fingers throughout the steps of the manœuvre.

Dr. X. O. Werder reports a case of

**Pregnancy Following a Partial Suprapubic Hysterectomy Complicated by Hemorrhage Through the Abdominal Cicatrix.**

Previous to operation the patient had been subjected to the application of electricity after Apostoli's method for two months, fifteen applications in all, varying from one hundred to one hundred and fifty milamperes. This treatment neither affected the size of the tumor nor did it produce the slightest symptomatic improvement, so that the patient clamored for operation. The tumor was attached by a very broad and thick pedicle to the posterior and right surface of the fundus of the uterus. The base of the tumor was encircled by an elastic ligature, above which the pedicle needles were passed, and the tumor removed above this point. The uterine cavity had not been opened, though subsequent events proved that part of the uterine tissue had been included in the ligature. The pedicle was fixed in the lower angle of the wound in the usual way. Pedicle and ligature came away onthe twentieth day and the patient left the hospital about six weeks after the operation with a small fistulous opening at the bottom of the abdominal wound. She missed the second period after the operation and developed symptoms of pregnancy. At the end of the fourth month there was a copious hemorrhage from the fistulous opening, which by this time had become enlarged from internal pressure to the size of a half-dollar, the amount of blood lost being at least a pint according to the estimation of the patient. There were seven hemorrhages in all, five of which were profuse, producing marked anæmia of the patient and causing a great deal of anxiety as to the ultimate result. Labor began three weeks before the expected time and the first stage was very slow. Labor was terminated by forceps. During labor there was only a slight oozing from the fistulous opening. The child was living but was very small and thin. The placenta was found adherent just under the fistulous opening and required manual separation. At this place the hand in the uterus noted an apparent absence of the uterine wall, and the placenta seemed to be attached to the abdominal wall around the external sinus. The abdominal wall was extremely thin, as could easily be ascertained by the hand placed over it and pressing against that in the uterus. Patient made an uninterrupted recovery. The reporter states that there is no doubt in his mind that the slough under the elastic ligature extended into the body of

the uterus and on separating opened into the uterine cavity; and that there was a direct communication between the fistulous opening in the abdominal wound and the uterine cavity, which allowed some of the menstrual blood to escape through it at her menstrual period; and that, furthermore, the source of the hemorrhages during pregnancy was the placenta itself, the upper edge of which was attached immediately under the bleeding surface.

The principal points in the case described are:

1. The menstural discharge through a small fistulous opening remaining after a partial supravaginal hysterectomy, which communicated with the cavity of the uterus.

2. Pregnancy occuring eight or nine weeks after operation in a woman previously sterile, in spite of a utero-abdominal fistula.

3. Pregnancy terminating in the delivery of a healthy though poorly developed child, at or at least near, the end of her term, in spite of a firm and unyielding fixation of the uterus to the abdominal wall, and in spite of frequent and profuse hemorrhages, from the placental site, through a sinus opening in the lower angle of the abdominal cicatrix.

Dr. H. Meek reports

**A Case of Tubal Pregnancy With Some Peculiarities.**

The peculiarities consisted in:

1. Situation above and in front of the uterus, between it and the pubes, the usual situation being behind the uterus.

2. The uterus being retroverted behind mass and on the same side instead of being displaced to the opposite side.

3. The intermittent contractions, which were so like contractions of the pregnant uterus as to lead one to think it a case of pregnancy in one horn of a double-horned uterus.

After examining the literature at his disposal, the reporter comes to the conclusion that the situation of the tube sac, above, in front, with the uterus back and on the same side, is unique.

No flushing or drainage was used at the operation. The patient made an uninterrupted recovery.

Dr. A. Brothers discusses

**The Present Position of the Electrical Treatment of Extra-uterine Pregnancy.**

The author finds that twenty-five cases which he has been able to trace were doing well after a lapse of one to eight years, and that none of them had been compelled to undergo secondary operations. Many of these patients still carry traces of the old trouble, but without perceptible inconvenience. The author analyses the literature on the subject, presenting a table of cases treated by electricity. He finds that only one death—that of Janvrin's patient—has occurred in seventy-eight cases in which electricity was employed without puncture, and in this case there were marked symptoms of hemorrhage previous to the resort to electricity. Of the seven cases treated by electro-puncture, there were five recoveries and two deaths. This proves that electro-puncture is a very dangerous method. The bad results being undoubtedly due the puncture and not to the current.

Dr. W. S. Christopher, presents

**A Plea For the Study of Pediatrics.**

It is the author's opinion that every reputable medical school should appoint a full professor of pediatrics. This professor should include in his lectures and clinics not only a discussion of the diseases of children, but, so far as time will permit, he should impress upon his class the wide scope of the subject and elicit an interest in its development. He should use his influence with the faculty to establish in the school a study of the fundamental branches upon which his own is dependent. Thus in anatomy he should secure the dissection of infants and the study of embryology in a properly equipped laboratory. In physiology and chemistry he should secure the laboratory work on the chemistry of food stuffs, the processes of digestion, assimilation, and elimination. In pathology the morbid anatomy and bacteriology of early life should receive formal attention.

Dr. Andrew F. Currier contributes an article on "Myoma Uteri and Its Treatment." [An abstract of this paper appeared in *The Annals of Gynæcology and Pædiatry* for November, 1893, and was reviewed in the issue of THE MEDICAL AND SURGICAL REPORTER for December 2, 1893.—ED].

The remaining papers in this issue are: The report of "The First Symphysiotomy in America," by Dr. Wm. Thomas Coggin; the continuation of the paper by Dr. Anna M. Galbraith on "Poliomyelitis Anterior Acute Infantilis;" and a paper by Dr. Flanklin H. Martin on "Ligation of the Broad Ligaments of the Uterus for Uterine Fibroids," with the report of the author's sixth case. The operation was a complete success.

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THE MASSACHUSETTS MEDICAL JOURNAL

for January contains a paper by Dr. D. J. Kelley on

**Tubercular Meningitis,**

reporting a case. The patient was a little girl of nine years, the child of healthy parents. The first symptoms were noticed about three weeks before the doctor's first visit and consisted of nothing more than a gradually increasing hebetude and sleepiness accompanied by a slight headache at the vertex. No impression was made on the patient by any treatment and she gradually sank, toward the last refusing all food. The temperature was taken daily; there was no increase until twenty-six hours before death when it rose to 99½°. The pulse although very weak, was always regular and never more than 90, until the last two days, when its frequency rose to 140 shortly before death, which occurred quietly, without the least struggle, ten days after the doctor's first visit. There was no paralysis or paresis; no convulsions; no papillary or visional disturbances at any time; nothing but a constantly increasing headache and sleepiness from the beginning of the attack to the dissolution of

the patient. The following is the report of the post mortem:

Removing the calvaria no adhesions were noticed between the dura mater and the bone. The dura mater itself was very tense, and slight adhesions along the longitudinal fissure could be readily observed between it and arachnoid. The tubercular character was at once manifested on the removal of the dura mater. The tubercular granulations were moderately sprinkled on the whole convexity of the brain, especially along the sylvian fissures. And where the tubercles were most abundant a very slight amount of lymph could be seen. Removing the brain and examining the base the same was noticed; the tubercles, however, existing in greater abundance, and lymph had been thrown out in greater quantity, especially over the central portion of the base, the optic commissure, and the pons. The vascularity of the brain was well marked. The ventricles were filled with a large amount of clear serum and the tubercles were largely disposed over the choroid plexus.

Dr. E. A. Lewis discusses

**Rigidity of the Os Uteri,**

reporting a case. The patient was twenty-nine years old, plethoric habit, and in her first confinement. The doctor first saw her after she had been sixteen hours in labor. He found that the waters had been escaping gradually since the first hour of labor; pains frequent and very lancinating. Having waited three hours, and finding the os not inclined to dilate, the author prescribed an opiate, and directed the vagina to be syringed with a tepid antiseptic solution. Two hours later there had been no improvement. Three one-grain doses of opium were given at intervals of an hour without effect. Extract of belladonna was also applied to the os without result. After the woman had been eighteen hours in labor the author decided to resort to operative measures. By careful manipulation the index and middle fingers were introduced within the os, and it was thus expanded to the extent of two inches in diameter. Owing to the exhausted condition of the woman, the author decided to terminate the labor at this point by the use of the forceps. A living nine-pound child was delivered, the mother made a good recovery. The author advises the employment of the above treatment in cases of rigidity of the os. The author speaks of an experience of seven cases in which he practiced the method and delivered five living children; all the mothers made a good recovery. He advocates the early resort to the forceps in such cases. When rigidity is confined to the os and neck, caused by some former organic disease of these parts, the treatment must necessarily be somewhat different. Should there be any hardened cicatrix of the os, the result of former ulceration or inflammation, incision of the cervix may be necessary.

Dr. Frederick Wallace Abbott contributes a paper on

**The Antipyretic Value of Hot Water used Externally.**

Its use is especially recommended in those cases of enteric fever characterized by a cool surface, feeble cutaneous circulation, and marked depression, where the thermometer will disclose a very high temperature showing a determination of blood to the great vessels and internal organs. The class of cases in which hot water may be profitably employed, the method of its application, and the auxiliary measures to be adopted, must be determined at the bedside. Broadly speaking, however, the young, the old, the debilitated, and those of a nervous temperament, are most benefited by the hot-water treatment, although its use is by no means restricted to these. As to the method of using hot water, this must be adapted to individual needs, the facilities at hand, and, as most of us sadly realize, the notions of the family and neighbors. In the treatment of meningitis, the exanthemata, and other febrile conditions in the young, we put the little patients into a warm bath, and gradually add hot water till the desired temperature is reached. A sense of comfort will be immediately experienced, and the patient may fall into a quiet slumber while in the bath. The bath should not last over fifteen minutes, when he should be gently rubbed dry, wrapped in a blanket, and returned to bed. If cardiac weakness exist, a little stimulant may be administered just before the bath; and, though held to be contraindicated in cases of fatty heart and atheroma of the great vessels, the author has yet to see any ill attend this treatment. The process may be repeated several times during the day, the guide to its frequency being the benefit derived. If it be deemed inadvisable to employ the hot bath, much good may be had from frequently sponging the entire surface, and hot cloths profitably be applied to the head, spine, and chest. Many who shrink from the application of cold water, and are even injured by it, will derive much satisfaction and benefit from hot sponging, and request its frequent repetition; and an antipyretic agent of no mean value is offered, the author believes in this treatment.

The remaining paper in this issue is by Dr. R. E. Anderson, entitled "Medicine as Practiced by the Lower Animals." In it the author points out the remedies selected by the sick animal, such as the various grasses.

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### Lysol in Obstetric Practice.

Israelson (*St. Petersburg med. Woch.*, No. 47, 1893) urges the use in obstetric practice of lysol as having greater antiseptic properties and a less poisonous action than any coal-tar derivative hitherto known. He uses a 1 per cent. solution for the skin, etc., and a 2 per cent solution for instruments, this preparation being less milky than the former. No pains, but only slight burning sensations are produced by the use of either, and it has no irritant action on the skin. Owing to lysol forming a "lather" with water it is a substitute for soap, rendering unnecessary the inunction of the hands and the application of soap and water prior to operations. The author has tried lysol extensively during one year and a half with satisfactory results.

# PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

## MEDICINE.

### Catrin on Observations upon Mumps.

The author has made a careful analysis of 159 cases and concludes as follows:

1. Mumps being indifferently upon either side: generally the parotid swelling begins as unilateral, affecting the other side after a lapse of from several hours up to five days.

2. Prodermic symptoms are the rule. In sixty-two out of a hundred cases there is at the same time an inflammation of the pharynx.

3. In twenty-four cases out of a hundred there is an initial fever, ordinary slight, but it may rise to 40°C., and last four days.

4. The prognosis as to complications is not determined either by the degree of severity of the glandular swelling or the intensity of the pain.

5. In half the cases the submaxillary glands participate in the process.

6. The duration of the treatment should be at least fifteen or twenty-five days.

7. The disease attacks especially young men serving in the army.

8. It is evidently contagious, but the germ is easily resisted, and prolonged exposure is necessary to infection.

9 The period of incubation appears to be about fifteen or twenty days. Relapses are more common than generally believed as they occur in about 6 per cent. of cases.

10. A distinction must be made between the true orchitis of mumps and the simply testicular injection which is never followed by alteration in gland structure.

11. Among other complications may be cited rheumatism, otitis, localized œdema, endocarditis, albuminuria, and purulent orthritis.—*L'Union Medicale.*

### Harley (Vaughn) on Diabetic Coma.

After recounting his experiments in the porduction of artificial coma in dogs by the introduction of sugar into the circulation, Harley describes the coma as: 1. A stage of nervous irritation, which may be so severe as to assume the form of an epileptic convulsion, or so mild as to appear in the form of mere trembling of the skin. 2. A comatose stage which may merely amount to a few hours' drowsiness or extend to a deep coma from which the animal cannot be roused, and ending in death.

The cause of the preliminary nerve irritability stage is probably due to the formation of some as yet undetermined substances acting as an irritant to the nerve-centres, the comatose stage being in its turn due to the effects of various toxic substances combining to produce it. The coma seems to be principally due to a diminution in the alkalinity of the blood produced by the acid products derived from the breaking up of the sugar molecule, the acids combining with the sodium carbonate and bicarbonate as well as with the ammonia in the blood, and thus hindering the blood carrying the carbonic acid to the lungs for elimination; while there is at the same time a diminution in the oxygen absorbed, and thus the oxidation in the organism is hindred from being properly carried on by a process of tissue asphyxia.

The artificial coma produced in the writer's experiments, while it is exactly analagous to that occurring in diabetic patients, does not appear to depend upon an increase in the quantity of the sugar in the organism, but upon the increase that has taken place in its derivatives. In all probability the same products are being continually formed in the health body, but only in such small quantities and so gradually that they are either sufficiently rapidly eliminated or there is sufficient time for them to be further transformed, in the process of metabolism, into harmless substances, and consequently are never present in the blood in an amount capable of producing coma.

In the cases of diabetes due to diminished assimilation of the sugar in the organism, such as pancreatic diabetes, coma occurs when the sugar has disappeared from the urine. From some cause as yet undiscovered the normal power of breaking down the sugar molecule in the ordinary processes of metabolism has been regained, and since the quantity of sugar present both in the tissues and the blood had been previously increased, an excess of its products is produced, and hence the coma. This point is of practical importance, as it indicates that one ought always to be on the outlook for coma, whenever a diabetic patient's urine ceases to contain sugar, if its disappearance cannot be accounted for either by dietic or other treatment. By analyzing the urine and finding acetone, or aceto-acetic acid, as well as making quantitative estimation of the ammonia and the lactic acid in it, one may be able not only to predict the outset of coma, but prevent it.

The rational treatment founded on the results obtained from the experiments is to administer alkalies. If the symptoms are urgent and time is of moment, sodium carbonate might be administered subcutaneously or intravenously, the pulse being carefully watched in case of heart failure. At the same time, since there is so great a diminution in the oxygen absorbed, it is advisable to encourage oxidation. The inhalation of pure oxygen may help, as well as trying to improve oxidation by massage. Diuretics together with large quantities of fluid hasten the elimination of the toxic products derived from the sugar.—*Brit. Med. Jour.*

### On the Restriction and Prevention of Tuberculosis.

The committee appointed by the American Public Health Association, in conjunction with the International Congress of Public Health, has published the following report:

1. Tuberculosis has been conclusively demonstrated to be contagious, by bacteriological experiments, by clinical observations, and by a study of the history of the disease.

2. Tuberculosis is a preventable disease. Its preventability follows as a logical sequence upon its contagiousness, but has likewise been demonstrated in a practical life.

3. The contagium of tuberculosis resides entirely and solely in broken-down tubercular tissue. A person suffering from tuberculosis, therefore, does not become a source of danger to others until he begins to give off broken-down tubercular tissue, either in the form of sputa from the throat or lungs, diarrœal discharges from the bowels, or matter from a tuberculous sore, such as lupus, white swelling, cold, abscess, scrofula, or tubercular inflammation of a joint.

4. A person suffering from tuberculosis can be made entirely harmless to those about him by thorough sterilization of all broken-down tissue, immediately upon its being given off. With proper precautions it is, therefore, possible to live in the closest relationship, and upon the most intimate terms, with consumptives, without contracting the disease.

5. Tuberculosis is not hereditary. A predisposition to the disease can be transmitted from parent to offspring, but this is more true of tuberculosis than it is of all other contagious diseases.

6. A predisposition to tuberculosis can be created anew by malnutrition, or by anything which depresses the nervous system.

7. Tuberculosis affects animals as well as man, and is identically the same disease in both. In domestic life human beings and animals mutually infect each other.

8. The media through which human beings are ordinarily infected by animals are milk and meat.

9. Houses in which consumptives have lived, and in which immediate sterilization of all broken-down tissue has not been practised, are infected houses, and are liable to convey the disease to subsequent occupants.

10. Spitting upon floors and into handkerchiefs, and permitting the broken-down tissue to dry and become pulverized, is a prolific cause of spreading tuberculosis.

11. Temporary occupation of hotel rooms, sleeping car berths, and steamer cabins by consumptives in the infectious state, can infect them so as to convey the disease to subsequent occupants, unless proper precautions are taken against contamination of the bedding, furniture and walls with booken-down tubercular tissue.

We recommend the following practical measures for the prevention of the disease:

1. The notification and registration by health authorities of all cases of tuberculosis which have arrived at the infectious stage.

2. The thorough disinfection of all houses in which tuberculosis has occurred, and the recording of such action in an open record.

3. The establishment of special hospitals for the prevention of tuberculosis.

4. The organization of societies for the prevention of tuberculosis.

5. Government inspection of dairies and slaughter houses, and the extermination of tuberculosis among dairy cattle.

6. Appropriate legislation against spitting into places where the sputum is liable to infect others, and against the sale or donation of objects which have been in use by consumptives, unless they have been thoroughly disinfected.

7. Compulsory disinfectants of hotel rooms, sleeping car berths, and steamer cabins which have been occupied by consumptives, before other persons are allowed to occupy them.—*N. Y. Med. Record.*

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**Koster (H.) on the Treatment of Erysipelas.**

During the past year Koster has treated about fifty cases of erysipelas with local application of white vaseline. A moderately thick layer of vaseline is applied with a brush over the affected area and over the surrounding healthy skin. Over this is laid a piece of ordinary linen, or, in case the face is affected, a linen mask with openings for eyes, nose, and mouth. The dressing is held in place by a gauze bandage. Fresh vaseline is applied twice daily and the same saturated mask is again laid over it and bound down. The results were exceedingly favorable, being quite as good as those obtained by painting with iodine, ichthyol, or corrosive sublimate-lanoline. In most cases the fever fell by crisis in a few days, usually two or three; pain and tension diminished rapidly, and relapses were not more frequent than under other treatment. The success of the treatment was sometimes surprising. The area of inflammation did not increase in most cases. Good results were obtained on the scalp without removing the hair. The method of treatment is recommended by its simplicity and freedom from dangerous or irritating properties.—*Centralblatt f. Klin. Med.*

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**Hysterical Œdema.**

W. Gajkevicz (*Gaz. lekarska*, No. 39, 1893) reports the following case: A girl, aged 18, previously quite healthy, suddenly noticed a swelling of her right upper extremity, but, as no pain or redness or rise of temperature was present, she paid no attention to it. After three weeks, pain of a localized character set in the swollen extremity; the right leg also became painful, and after a short time the patient lost her voice. She was well nourished, and the organs of circulation and respiration, and the kidneys were normal. The right arm was 2 to 4 centimetres thicker than the left; not painful; no "pitting" on pressure, pale, with a temperature of 33°C. (as against 35°C on the left), and greatly increased secretion of sweat. Pricking with a needle did not cause bleeding in the right arm, but was followed by a rather obstinate urticaria. During the seven months she stayed in the hospital the right breast and right leg down to the knee also became œdematous. The absence of any disease of the heart and kidneys, and the presence of nervous disturbance, determined the diagnosis of "hysterical œdema."

## GYNECOLOGY.

### Wyhe (W. Gill) on Dysmenorrhœa and Chronic Endometritis.

Undue importance has been attached to retroversion, and other displacements as the direct cause of symptoms. Displacements simply complicate disease, and may give rise to pain, which, however, is due less to the displacement than to other conditions.

When the broad ligaments are thickened, and the tubes and ovaries diseased, pain will be experienced, as the subject assumes the upright position, even when there is no displacement from the downward pressure exerted upon the fixed uterus and diseased ovaries. When the uterus is healthy, displacement causes but little trouble.

If retroversion exist, next determine whether the case be complicated by disease of the endometrium, or by salpingitis.

If disease of the tubes and ovaries be present, the only procedure is their removal. We cannot treat disease of the Fallopian tubes by curetting and draining. We cannot reach the seat of disease except by laparotomy.

If no such complication exist, boro-glyceride tampons should be placed twice a week between the menstrual periods—but pessaries have no place in treatment.

If such treament fail to effect involution and improved circulation, and the introduction of the sound cause bleeding, or pain, then douche, curette, and drain, making a simple application—never one that will destroy the mucous lining with its deep seated glands and follicles, leaving a scar that will do more harm than good in after life.

As to the curetting, the sharp instrument only is worthy of use. The blunt copper wire currette may turn up the granulations, but will not remove them, leaving behind a better nidus for sepsis than before the dilatation. When there are large pieces of tissue to be removed, blunt and rounded forceps are to be used.—*Internat Jour. of Surg.*

## OBSTETRICS.

### Zabala (L.) on Resuscitation of the New-Born.

The instrument suggested consist of two parts, the catheter and the ball. The catheter is metallic and curved in one half whose end fits to the shape of the infant's glottis, with one hole on the outside for the passage of the air. The curve of the catheter is regulated by the convexity of the floor of the mouth. The exterior end is straight and adapted to one opening of the elastic ball. This ball is made of soft rubber, and has two openings, one with a metallic aperture, to receive the outer end of the catheter, and the exterior to allow the entrance of the air. Its capacity is calculated to answer to the inspiratory capacity of a new-born's lungs, thus avoiding the risk of their over-distending.

The infant in Sylvester's position, or better still, in a pail of hot water, as in De Forest's. After cleaning the fauces with my fingers wrapped in a cloth, I enter the mouth again with my bare left index pressing the tongue till I feel the epiglottis; I go as far as filling the cavity of the glottis with the point of the finger. Once there, I hold my catheter and carry it to the larynx, when I push the end straight into its cavity. I keep it in place with my left hand, while with my right I fix the empty ball to the outside and I next produce a movement of aspiration that answers very well for the purpose of emptying the new-born's trachea and bronchi of all foreign substances that may have lodged there. I clean, then, the ball and apply it empty again until I believe that the respiratory passages are totally free, and not until then do I force the air into the lungs. The movement of the insufflator ought to be made at the rate of from fifteen to twenty times to the minute and continued with hope of success as long as the beatings of the heart are not totally extinct.—*Loth. Cal. Practitioner.*

## ARMY AND NAVY.

U. S. ARMY, FROM DECEMBER 31, 1893, TO JANUARY 20, 1894.

The extension of leave of absence granted Captain Charles E. Woodruff, Assistant Surgeon U. S. Army, is further extended one month and twelve days.

Leave of absence for two months, on Surgeon's certificate of disability, with permission to leave the Department of Dakota, is granted First Lieutenant Charles F. Kieffer, Assistant Surgeon U. S. Army.

Leave of absence for one month, on Surgeon's certificate of disability, is hereby granted to Major Edward B. Mosely, Surgeon U. S. Army.

## NEWS AND MISCELLANY.

The Medical Society of the State of New York will hold its eighty-eighth annual meeting February 6, 7, and 8, in the City Hall, at Albany.

Communications relating to the presentation and reading of papers should be addressed to the business committee *prior to the 1st day of February.* Dr. Henry Flood, Elmira, N. Y.; Dr. L. Bolton Bangs, 31 East 44th St., New York City; Dr. Edward Clark, 271 Franklin St., Buffalo, N. Y.

The faculty of the Medico-Chirurgical College, of Philadelphia, has erected three new clinical chairs, viz: Genito-urinary surgery, orthopedic surgery and otology. These together with the vacancy in the chair of clinical medicine will be filled permanently at the end of the present session.

THE
# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### CINCHONA IN MALARIAL AFFECTIONS.

R. G. SAYLE, M. D., Hale's Corners, Wis.

In 1638, the Spanish Viceroy's lady, Princess De Chinchon, was sick with a fever at Lima, and a decoction from the bark of a native tree was administered and the patient cured. The tree was named after this noted patient, and ever since that date cinchona preparations have been held in high esteem in the treatment of all fevers, and especially have the virtues of this drug been demonstrated in the cure of malarial fever. Indeed, the action of the agent is so well understood, and its administration so effective of good results in the hands of the average practitioner, that I feel timid in presenting a paper on this subject.

However, in view of its great importance as a curative agent, placed second only to morphia in our Materia Medica, and in view of the extensive experimentations and studies of later years as to the *modus operandi* by which quinine cures malaria, the best preparations to use, proper dose, best mode of and form for administration, time to administer and value and use of the drug as a prophylactic in malarial diseases, that I offer the following brief outline of cinchona in malarial affections as my convictions resulting from reading the opinions of noted writers and investigators on the subject, coupled with quite an extensive experience of my own with the agent in the treatment of these diseases during the past three years.

We have in cinchona preparations a positive remedy for the active manifestations of malaria. I do not mean by this to include every ailment with periodical phases of expression, but those diseases the result of the entrance into and development and multiplication within the circulation of the malarial organism termed *Plasmodium malariæ*. The periodic processes in an individual affected with malaria are no doubt dependent upon certain phases in the development of these particular low forms of animal life. Quinine being absorbed and entering the circulation meets with these organisms and exercises a restricting power over their development. If the dose administered has been sufficient, the next expected paroxysms will be averted; if not, the remaining active organisms pass on to the reproductive stage and another paroxysm occurs proportionate in severity to the lack of efficiency of the first dose given. The recurring expressions of renewed activity at remote periods are most likely due to development from latent parasites which were located outside the circulation where the effect of quinine was not felt.

*Mode of Administration.*—Having diagnosed our case, we have three practical methods by which to introduce the remedy, viz., the stomach, rectum and hypodermically. Administration by the stomach will offer the least obstacles in the vast majority of cases, the rectum being resorted to in case great nausea or vomiting is present, or the patient cannot or will not take the medicine otherwise.

The hypodermic syringe may be used in

case of a pernicious attack, or whenever profound malarial poisoning is present, and more certain and rapid action is required. Favorable sites for injecting are the buttocks, between the tuberosity of ischium and great trochanter, over the lumbar region and in upper arm. These sites are less sensitive, and in case of a possible abscess resulting, the points of least inconvenience.

*Preparation to use.*—Of the many cinchona preparations the salts of the alkaloid quinine possess every advantage to be derived. For stomach administration the sulphate of quinine answers well all requirements, unless it be in the case of children, when the question of palatableness may influence the physician to choose the tannate. For rectal administration the sulphate answers all purposes. For use in the hypodermic syringe solubility is desirable, and the hydrochlorate has become most popular, though the sulphate is deemed as worthy by many. Quite recently two French physicians and chemists, Drs. Laborde and Grimaux, have brought forward a new salt of quinine, viz., the chlorosulphate, possessing the same action as the ordinary sulphate in similar doses, but soluble in its own weight of water, and said to give rise to much less pain when administered hypodermically than is caused by any other quinine salt.

*The size of the Dose.*—Ten to fifteen grains per day of the sulphate will break up the paroxysm of an ordinary case of malaria, and more than forty grains are seldom needed for the worst cases. It has been determined that five grains of quinine sulphate in the blood of an ordinary individual gives a proportion, the strength of which will destroy the reproductive powers of malarial organisms. Quinine is very readily absorbed by the rectum when retained, and the dose need be but little larger than that taken by the stomach. Five to fifteen grains of the hydrochlorate may be given hypodermically. Quinine tannate possesses about one-fourth less alkaloid than the sulphate.

*Time of Administration.* — The best time to administer quinine is in the decline of the febrile stage or in the sweating stage of the intermittent form of the disease. A full dose should be given at this time, from fifteen to twenty grains, and if another paroxysm fails to occur, the dose need not be repeated, but if a rise of temperature occurs again, give a smaller dose as the temperature wave declines. I am a firm believer in the temperature wave as indicating the time to administer quinine rather than the occurrence of chills, as I have met many cases where, though chill failed to recur, the temperature nevertheless rose to from 103° to 105° F. There is no need of repeating the dose of quinine when neither chill nor rise of temperature recurs, but serious mistakes will often be made if the dose be omitted because the patient reports "no chill to-day." When disagreeable symptoms ensue from the administration of ordinary sized doses of quinine, three, or four, or five grain doses should be given at intervals of two hours, or even smaller doses less frequently, proceeding cautiously until cinchonism is produced. It is a common practice to give a full dose of quinine at intervals of seven days for three or four weeks following the last paroxysm, for the purpose of preventing the expected renewed activity of latent organisms, and perhaps there are not many objections to this practice where quinine is well borne; but in other cases a careful watch is kept over the reappearance of slight symptoms, whether nervous, pertaining to the digestive tract, or otherwise, which usually mark each individual case, and then dose the case if a slight temperature rise is shown by the thermometer. I have not observed this return of the paroxysms in the great majority of my cases. These recurring remote paroxysms are less apt to be experienced where treatment is begun before the system is very much impressed with the disease.

*Form of the Dose.*—With the advent of wafers and the gelatine capsule much of the objection of taking this drug was banished. We do meet those who cannot swallow a capsule or wafer, and object to having their skins pierced or rectum disturbed, so that there is a call for some way other than these for preparing the dose. By many the bitterness is tolerated when given in any form of solution; and I have found that a full dose of quinine placed on the tongue, the mouth closed and a flow of saliva excited, with which the powder is incorporated and swallowed, gives very little bitter taste—the concentrated dose is such that the sense of taste is paralyzed. If the tongue

be first moistened with licorice, a dose of quinine may be given in plain water without any great ojection. Many children of four years and over will swallow a capsule if rightly guided in their efforts. My plan is to first give a teaspoonful of water to moisten the mouth, then give the capsule with directions to roll it about in the mouth (making no mention that they are to swallow it) until it becomes slippery. When the patient says it is in such a state give a glass of water from which to take a good swallow or two, and the pill usually disappears. Members of the family or others, looking on, admonishing "Johnny" to "swallow it!" and "don't bite it!" etc., will usually frustrate the success of this plan. It is easy for a child to swallow a capsule unconsciously and just as readily he can prevent the act, if his attention is directed in particular to the dose. The tannate of quinine is a very eligible preparation for children. It may be extemporaneously prepared as follows: Quiniæ, twenty-four grains; acid tannic, twelve grains, mix with two ounces of syrup of cinnamon, or, if the sulphate be used, double the quantity of tannic acid. For hypodermic injection, quinine hydrochlorate, twenty grains; acid hydrochloric, five drops, and water distilled fifteen minims, may be compounded, fifteen minims corresponding to about seven and one-half grains of neutral muriate of quinine. Quinine sulphate mixed with a little water, and dilute sulphuric acid added drop by drop until the salt is dissolved, and enough more water added to make the desired quantity, answers well.

The new salt chloro-sulphate may be dissolved in an equal weight of water. For intravenous injection, quinine hydrochlorate fifteen grains, sodium chloride eleven and one-half grains, add water distilled, two and one-half fluid ounces, mix, boil and filter the solution before using. For rectal administration dissolve ten to thirty grains of sulphate of quinine in dilute sulphuric acid, add a few drops of laudanum, and make the quantity two to four ounces by the addition of wator, and inject through a rectal tube well up in the bowel.

*Idiosyncrasies and Contra-indications.*--Most of these may be overcome by judicious administration as to time and dose. Unpleasant brain symptoms are improved by giving a full dose of bromide of potassium or hydrobromic acid. My own experience with the drug in pregnant women has convinced me that no contra-indication to its use exists. In middle ear affections quinine should be given in small doses. There are many minor expressions of idiosyncrasy toward quinine which must be tolerated in view of the known benefit to be gained.

*Quinine in the Prevention of Malarial Infection.*—There will be no development of malarial organisms in the blood when a sufficient amount of quinine is in the circulation, consequently ten grains of quinine sulphate may be taken daily on coming into an infected locality, especially if one must needs be exposed at night or occupy lower rooms for sleeping apartments, or live on low ground. If these disadvantages are not present, or proper hygienic surroundings can be secured, continued use of quinine may be omitted.

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THE TONGUE IN "LA GRIPPE."—"La grippe" is a disease which, simulating as it does various other pathological conditions, is often puzzling from a diagnostic point of view. Who, on being called to cases of "la grippe," has not thought of such possibilities as typhoid fever, acute tuberculosis, cholera, simple "embarras gastrique," etc. If one may believe M. Faisans (*Societe Medicale des Hopitaux*, May 19) examination of the tongue will disperse all such doubts. The tongue in "la grippe" is of the normal size and form, not being broad and thick, as in "embarras gastrique," or small, contracted and pointed, as in typhoid fever. It is always moist, unless some inflammatory complication be present or imminent; it is smooth and even, papillæ not being prominent. But the chief characteristic feature of the tongue is its color, it is the *opaline tongue*. The opaline coloration is sometimes uniformly spread over the whole lingual surface; in other instances the middle and the base are opaline, the edges and tips being covered with distinct rounded opaline or bright red spots. This pathognomonic appearance may be often noted from the first onset of the disease and may persist for a more or less prolonged period after recovery. Purgatives and emetics do not modify it in any degree.—*Lancet* correspondence. *Maryland Medical Journal.*

# LITTLE HELPS AND LITTLE HINTS CONCERNING THE PROPER FEEDING OF INFANTS.

JAMES ALLEN PATTERSON, M. D., SALEM, N. J.

No doubt every practitioner has been frequently impressed with the increasing inability of mothers to suckle their offspring, and the difficulty of obtaining a proper substitute for nature's provision. It therefore behooves us to study deeply and observe minutely, that we may meet the various demands made upon us, and surmount obstacles as they arise.

I have oftimes noticed the inability of the laity to appreciate the fact, that infants require feeding in proportion to their digestive ability and constitutional requirements. Many mothers labor under the erroneous impression that because an acquaintance feeds her babe in a particular manner, her own child, which may be of the same age but of entirely different diathesis and digestive capacity, can subsist or thrive upon a like regimen. There are more infants starved in cell-growth than many are aware of. While some may manage to make out a fretful and diseased existence in babyhood and suffer through life from the ills due to a depraved constitution, many perish by the wayside an easy prey to some epidemic which may attack them.

I am firmly of the belief that a child, particularly if fed upon an artificial food, should be constantly watched, and when it is found that sufficient gain in body weight is not being made monthly, that its flesh is pale, flabby or in any wise of unhealthy appearance, that it is not sleeping well or is fretful, its diet should be varied or radically changed and any constitutional dyscrasia prescribed for. It is my experience that a child who digests well and is properly nourished, sleeps well and is happy and good humored, at the same time making continuous gains in size and weight while maintaining a healthy complexion and elastic flesh. Children that are fretful and sleepless are as a rule fed in a faulty manner or upon food which they cannot fully digest.

As a substitute for breast milk, we naturally turn to cow's milk, from the comparative ease with which it can be obtained and the experience which every one knows of its ordinary adaptability. But cow's milk has disadvantages, which have been frequently pointed out, namely: its excess of curd and its acid reaction.

The excess of curd is somewhat counterbalanced by dilution, and its acid reaction by alkalies, but in subtracting the excess of curd by dilution we lower the amount of fats and albuminoids, thereby losing elements of food value.

The dried preparations of milk and starchy ingredients, sold as various infants' food have rightly been tabooed by eminent and experienced clinicians.

Years ago, Charles D. Meigs, saw the advantages derived from cream and milk, to which was added a starchy ingredient. The food compound bearing his name, consists of cream, milk, arow-root, gelatine and sugar. While not an ideal compound, having the disadvantage of containing starchy ingredients in a form not easy of assimilation, the gelatine being of questionable food value and the cane sugar too prone to ferment, it did a good work in its day.

Various cream mixtures have been proposed and used since the time of the elder Meigs. The leading ones being those of his son, A. V. Meigs, of Biedert, and of Rotch.

The above three compounds while being very similar in composition are almost identical in analysis to that of breast milk, and agree with some infants. They have the disadvantage of being troublesome to prepare and keep, in addition to containing sugar of milk, an article which is liable to contain gritty particles, which do not always dissolve promptly; an article which is quickly "converted into lactic acid, so that the excess of acid accumulates in the stomach and causes the protein substances to coagulate and become indigestible; it dissolves the alaklies and calcium out of the phosphatic combinations to no purpose except to produce dyspepsia and diarrhœa and, according to Heitzmann, rhachitis," (p. 49. Jacoby Intestinal. Diseases of Children). In addition "many specimens of milk-sugar have been found to contain bacteria derived from the milk from which it is made."

(Neuman *Berl. Klin. Woch.*, 1893, No. 22, quoted in *Am. Med.-Surg. Bull.*, December, 1893) the low temperature habitually used to separate it from the milk not being sufficient to kill them.

Rotch, whose formulæ is—

℞
Cream (twenty per cent).....3iss
Milk.....3i
Water.....3v
Milk Sugar.....3iij¼
Lime Water.....3ss

makes a very strong point in his mixture by advising the use of centrifugal cream, the ordinary strength of which is twenty per cent. This manner of separating the cream from the milk by machines making 7000 to 9000 revolutions per minute, cannot fail to produce a more minute subdivision of the globules than is obtainable in the old manner of skimming, or the somewhat similar plan of drawing the milk from the cream by gravity. Centrifugal motion has in addition a cleansing action upon the product, as after the machines have been in use, their sides are found filled with a filthy ingredient, resembling a tough curd containing pus, blood and filth from various sources. I speak from ocular inspection, having made no microscopical examination of it.

The requirements for an ideal food for infants appear to be dilution to lessen the proportion of curd, the addition of cream to supply the requisite amount of fat and of an assimilable form of starchy ingredient to maintain the separation of the curd in finely divided masses, whilst supplying certain deficient and valuable food values, and an alkali to counteract the acidity of the cow's milk.

The amylaceous ingredient can only be obtained in assimilable form by converting the starchy grains used into the diastasic products dextrin and maltose, while maintaining much of its mechanical effect upon the minute subdivison of the curd.

My plan has been to use cream, or cream and milk with Mellin's Food, a food which consists of the dextrin and maltose products of wheat and barley alkalanized. It supplies the sweetening power and albuminoids in a much more palatable and digestible form, than the cream mixtures above spoken of. I have used both and believe the food compound is more easily digested and has given me better results. And is it to be wondered at when we recall the researches of Musculus and O'Sullivan, who confirm the physiologically important question *that* the action of malt diastase is identical with the action of the salivary and pancreatic secretions, ptyalin and amylopsin. (Digestion and Diet by Sir Wm. Roberts, p. 26). Again the experiments of Schiff have proven that "in many cases of vomiting" dependent upon insufficient formation of pepsin, injections of solution of dextrine will enable the stomach to resume its function, or being injected into the rectum, will furnish an absorption material for the secretion of pepsin." (Infant Diet by Jacobi, p. 96 and 105).

The following formula has given me excellent results:

For a child aged from three to six months, six to seven tablespoons of cream, with or without three of milk, three of Mellin's Food and water one quart, gradually increased to ten of cream, and five each of milk and of Mellin's Food to the quart. I direct that the cream and milk be first scalded with the desired quantity of boiling water, when sufficiently cold the Mellin's Food is to be dissolved in it and the mixture placed in a refrigerator. When the child is to be fed the mixture is stirred and sufficient quantity warmed, in this respect merely following the directions supplied with each bottle of the food.

When the patient's stomach is in a demoralized condition, I begin with the cream and Mellin's Food combination only. When that agrees I gradually add the milk.

A child of two months, suffering from marasmus is doing well upon a formula consisting of five parts of cream, one of Mellin's Food, and five of water. At first it required to be fed by the spoon, being too weak to draw from a nipple, and was only able to take four to six ounces in twenty-four hours. In a week, subsequently, it took a quart in twenty-four hours, while its digestion as shown by the cessation of diarrhœa and absence of colic, heretofore troublesome symptoms, has become normal. Its increase in body weight and growth is surprising.

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THERE were treated at the World's Fair Emergency Hospital, 18,500 cases, and there were 23 deaths at the institution.—*Pub. Opinion.*

# FRACTURE OF THE EXTERNAL AUDITORY CANAL BY BLOWS UPON THE LOWER JAW.

ROBERT BARCLAY, A. M., M. D.,† St. Louis.

Fracture of the osseous external auditory canal and its integumentary tissues by force transmitted through the inferior maxilla is not infrequent; and its importance arises from the fact it may be overlooked entirely or, if not so, mistaken for a fracture of the base of the skull or for a ruptured membrana tympani.

The mode of occurrence and the behavior of such cases are sufficient to place the medical attendant upon his guard against oversight or error is diagnosis; and it is with a view to contributing further to the stock of general information respecting this phase of the subject that the following clinical memoranda are displayed.

*80447l.*—This man, aged forty-nine years, first consulted me eight days after having been kicked upon the symphysis of the inferior maxilla by a mule. Following the injury, there had been free hemorrhage from both external auditory meatus for a day, when a moist antiseptic compress was applied to both ears. After several days, there was substituted for this dressing a wad of absorbent cotton-wool plugging the outlet of the meatus. A mephitic discharge, however, supervened, and was active at the time of our first consultation; upon which occasion, after properly cleansing the parts, although slight hemorrhage persisted from the canal wound, the diagnosis of fracture of the anterior-inferior bony canal wall and its coverings was readily made. A similar lesion, but without persistent hemorrhage, was found in the other ear. No lesion of either drum-head could be recognized.

The auditory canal was continuously distended with a tent of absorbent cotton-wool, tightly rolled, conical in form, saturated with an emollient, vulnerary ointment. The injured parts healed rapidly.

*604448.*—Ten days before our consultation, the patient, a man aged thirty-three years, had been kicked by a mule, sustaining thereby three scalp-wounds and a compound fracture of the inferior maxilla upon the right side. No aural injury had been suspected until the day before our consultation, when a discharge from the right meatus was discovered.

After the ear had been carefully cleansed, it was not found difficult to recognize a fracture of the anterior-superior and medio-inferior wall of the bony canal and its coverings. Search was carefully but unsuccessfully made for a suspected lesion of the drum-head.

Treated, as the preceding, with the ointment and cotton-wool tent, the patient, I have been informed, made a rapid recovery from the aural injury.

*604345.*—This man, aged forty-six years, complained that "his ears had felt stopped up for five weeks" preceding; that "his head felt as if it were full of water," and "sometimes as if there were a sticking in it, and as if it would burst." With the worse, the right ear, he could hear loud voice at three feet distance. Hitherto he had received no treatment.

On examination, the cartilage of the concha was, upon both sides, found slightly drooping at the meatus. The left auditory canal was found greatly narrowed by encroachment of the anterior wall, seemingly from diffuse bony growth thereof. The right one had in like manner been reduced to a mere vertical slit, about one-sixteenth inch wide at its broadest part; and it contained impacted cerumen, which was at once removed. There were two carious teeth upon the right side of the upper jaw; which doubtless by reflex irritation had induced the oversecretion of cerumen within the ear connected with them. In a search for the etiology of the deformity of the auditory canals, inquiry elicited the statement that ten years previously he had fallen a distance of thirty feet, sustaining a fracture of the inferior maxilla; and although he

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could not recall the condition of his ears nor assert the existence of any auditory symptoms at the time, when suffering intensely from his maxillary fracture, it may reasonably be inferred, from the aural appearances, that the glenoid process may have been fractured at that time.

*604171.*—The patient, a man aged twenty-eight years, while under the influence of liquor, was struck upon the zygomatic process of the temporal bone, and upon the inferior-maxillary joint of the right side. The right ear bled profusely for two days, clotting up with arterial blood. During that time hydrogen peroxide had been instilled into his ear three or four times a day.

Incidentally it was learned that he was quite deaf in the other, uninjured ear, having been so ever since an attack of scarlatina at the age of five years.

Upon the third day, when I first saw him, the clots, etc., were removed from the right ear; when without difficulty the lesion was identified as a fracture of the glenoid process with rupture of the anterior structures of the canal. Under treatment similar to that described above, the patient made a good recovery.

*604035.*—The occasion of injury in this case was unknown, it having occurred while the patient was intoxicated.

Two days after his mishap, I saw him, a man forty-nine years of age, and noted these facts; there were found, at that time, contusions and ecchymosis of the face; lymphangitis of the right fore-arm from trauma of its posterior portion; abrasion of the left auricle at the antihelix; left aural hemorrhage from a laceration of the left auditory canal, fractured by a blow that had produced as well a compound fracture of the inferior maxilla; and the left drum-head has been ruptured.

Under instillation of hydrogen peroxide and distension with the anointed cotton-wool conical wad, the aural injury rapidly healed, and the patient made an uninterrupted recovery.

# COMMUNICATIONS.

## HYSTERECTOMY.

L. S. McMURTRY, M. D., Louisville, Ky.

In connection with the two specimens, which I here present, I will report the cases which I deem of exceptional interest and illustrative of two of the most important classes of cases in pelvic surgery.

The first case is one of cancer of the uterus which I saw about ten days since in consultation with Dr. Krim. The patient had been bleeding for some time, and had suffered severely with reflex nausea and vomiting. A vaginal examination revealed the unmistakable symptoms of malignant disease involving the cervix. There was also a boggy mass within the pelvis to the right of the uterus, which I feared was extension of the disease in the broad ligament, but which proved to be a pyo-salpinx. One week ago yesterday I did vaginal hysterectomy and the operative technique was as follows:

For three days preparatory to the operation, the patient received daily and thorough vaginal douches of a solution of bichloride of mercury. Two days prior to operation I thoroughly curetted the uterus, removing the necrosed tissues. At the time of operation the vagina was again thoroughly douched, and the cervical canal packed with iodoform gauze. These precautions are essential in order to prevent infection of the peritoneum in the course of the operation. Seizing the cervix with forceps, it was drawn well forward and the tissues divided with the scissors posteriorly, opening the peritoneum into Douglas' space. At this stage of the operation a clean sponge, to which a strong ligature was attached, was passed into the peritoneum up above the field of operation so as to prevent descent of the intestines. With the index finger of the left hand as a guide, and after drawing the cervix backward, I divided the tissues anteriorly and dissected the uterus from the bladder, being careful to avoid the ureters. The incision in the vaginal mucous membrane was completed all the way round the cervix, and the uterus brought well down. I then placed a clamp on the left broad ligament near the

uterus and attempted to treat the right broad ligament in the same way. At this period of the operation I discovered the boggy mass, previously mentioned, was a pyo-salpinx on that side. When the clamp was compressed it ruptured, and pus ran down into the vagina. I divided the broad ligament on the left side, and also on the right, when I discovered that the right broad liagment was so disorganized that it would not hold the clamp. I caught up and tied the ovarian and uterine arteries on that side, and removed the diseased tube and ovary. After thoroughly irrigating, and seeing that all bleeding points were controlled, I removed the sponge from within the peritoneum, placed an iodoform gauze drain in the vagina, and around the clamps, so as to secure drainage. The patient was then placed in bed. I removed the clamps at the end of thirty-six hours; there was no hemorrhage. The patient has made an easy and uneventful recovery. She has had no vomiting since the operation, is nourishing well, and already exhibits marked improvement in her general condition.

An examination of the specimen shows that the infiltration has involved the body of the uterus, and that amputation of the cervix after any method would have failed to remove the diseased tissues. This has been the condition demonstrated in greater or less degree of every specimen that I have seen removed, and I am confident that total excision of the uterus is the only treatment worthy of consideration in cases of malignant disease of this organ. The mortality of the operation has been reduced until it is now a very safe proceddure, and the ultimate results would be a great deal better if the cases could be submitted to operation earlier in the course of the disease.

The second case is also one of hysterectomy, but wholly different as to the character of the disease and the method of operation. The disease is a large myoma of the uterus and the operation was done by the supra-pubic route. The superior border of the tumor lay on the inferior curvature of the stomach, and occupied the entire pelvis and the greater portion of the abdomen.

An examination of the specimen shows a peculiar formation of the tumor, which very materially determined the method of dealing with the pedicle. It will be observed that the tumor has a large nodule posteriorly which filled the hollow of the sacrum, and as I open the cavity of the uterus you will observe that the tumor is sub-peritoneal interstitial and sub-mucous, filling up the cavity of the uterus, obliterating the cervix so as to present the form of the gravid uterus at term. The patient is 32 years of age, and has suffered severely from pressure and hemorrhage. She was much reduced in flesh and strength. Since the tumor impinged upon the stomach she has suffered with frequent vomiting. On opening the abdomen, the incision extending from the pubes to sternum, I found difficulties in dealing with the broad ligaments on each side, and the bladder in front. The bladder had been carried upward by the tumor and I had to dissect it off from the anterior surface of the growth. I ligatured the broad ligaments on each side in successive sections, dividing them as tied, until I reached the floor of the pelvis, being careful to secure the ovarian and uterine arteries. Finding the peculiar formation of the tumor which I have described, I finished the operation by complete extirpation of the cervix, and closing the vagina, being careful to suture accurately the peritoneum. I completed the operation with very little loss of blood, and put patient in bed with a pulse of 97, without shock. I put in a glass drainage tube. It is now seven days since the operation and the patient has made one of the smoothest recoveries I have witnessed after abdominal section. I removed the drainage tube at the end of 24 hours and she has done well continuously. The pulse has remained under 100 throughout, and she has suffered no pain, never requiring a single dose of opium or of any anodyne. Indeed she received no medicine whatever except a saline purgative on the third day, and her convalescence has been exceptionally easy and uneventful. I have watched the case with unusual interest, as this is the first one of the series of abdominal hysterectomies which I have done in which I have treated treated the pedicle in this way. In all of my other cases I have treated the pedicle extra-peritoneally with the neude, and have had no reason to regret it. In this case I would have pursued that method but for the peculiar conformation of the

tumor, which necessitated complete excision. This latter point will be appreciated by an examination of the specimen before you.

Until recently professional opinion made very light of fibroid tumors of the uterus. They were pronounced benign, regarded as harmless, and the menopause held up to the patient as a period when cure will come in nature's own way. With increased knowledge of pelvic diseases it was realized that these tumors do not shrink away at the menopause, and that often they grow with increased rapidity after that period. Hemorrhage does not always cease at that period, and degenerative changes, often malignant, take place. Hemorrhage and pressure undermine the system and suffering is severe and protracted. Hypodermatic medication with ergot and local treatment by electricity may palliate, but they never cure. Surgical treatment alone can be relied upon in the treatment of these growths, a fact which is now very generally recognized by the profession.

A large proportion of fibroid tumors of the uterus may be arrested and even cured if treated in the early stages by removal of the uterine appendages. In some cases this operation will fail. It is only applicable to the early stage of these growths and especially in cases where hemorrhage is the conspicuous feature. In some cases where the tumor is of comparatively moderate size, one of the appendages may not be accessible by abdominal section in consequence of the altered relations made by these irregular growths. In many cases where the tumor is sub-peritoneal it may be removed by myomectomy and the integrity of the uterus preserved. This operation is applicable to sub-peritoneal tumors which can be enucleated without opening the uterine cavity.

Hysterectomy is the operation of widest application in the treatment of uterine fibroids. Operators are divided as to the best method of treating the pedicle—one division advocating the extra-peritoneal treatment of the pedicle with the wire *neude*, and the other adopting the intra-peritoneal method. It has been objected that the *neude* is the application of the same principle in this operation as the clamp in ovariotomy, and that it should be abandoned in like manner. It must be remembered, however, that the pedicle here is composed of muscular tissue, very prone to retraction and hemorrhage, and differing in the degree of vitality from the pedicle of an ovarian cyst. The extra-peritoneal method with the *neude* is practiced by Keith, Bantock, Tait and Price—their cases are the most numerous and their results the best. This method is, as a rule, easier of execution and requires shorter time, the latter being a very important factor in avoiding shock. This method requires skill and ingenuity in securing a pedicle, reducing it to small size, so that it can occupy small space in the lower angle of the incision and be divided by the wire without a wet slough. This method is an absolute guarantee against hemorrhage, since the pedicle is under the eye and hand of the surgeon and nurse.

The dropped pedicle is the method of Schrœder, and has been modified since his day. By some it is treated with several rows of sutures, and by others the cervix is completely enucleated. Results have undoubtedly improved recently by all methods, and each operator will doubtless do best with that method in which he has perfected himself and become familiar with details of managing the pedicle. In selecting between the two great methods of dealing with the pedicle it is important to bear in mind that hemorrhage is a great danger after this operation, and whatever method may be selected, the operation is a difficult one.

The results of hysterectomy for fibroid tumors have improved wonderfully within a few years past, and when the great element of time is more generally appreciated by the profession, the operative treatment will be far more successful. When the tumor is of moderate size and the system not exhausted by hemorrhage and pressure, the operation can be done with better results than in cases where the tumor has risen high up in the abdomen and the patient exhausted by loss of blood.

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**Profit and Loss.**

ELEANOR.—What does that Mr. Scribble do with all the money he gets for his jokes?

CONSTANCE.—He spends it in buying the papers to see when they're published.

OGDEN WARDE.

# ELECTRO-PUNCTURE FOR REDUCTION OF TONSILLAR HYPERTROPHY, WITH CASES.

S. G. DABNEY, M. D., Louisville, Ky.

This instrument is one for accomplishing the reduction of tonsillar hypertrophy by means of the electro-puncture. Cases in which it is used are generally adults. There are two reasons for the adoption of this method in preference to other means of removal of the tonsils: First, it lessens the danger of hemorrhage, especially in patients where there is a hemorrhagic diathesis; second, in cases where the tonsil is deeply situated it is quite impossible to catch them in the tonsillotome, and it would be dangerous to attempt removal by the knife or scissors. In the opinion of a great many surgeons in this department, the removal of tonsils in the adult in any case is attended with serious danger of hemorrhage. In regard to the flat, deep-seated concealed tonsils, two or three cases occur to me at the moment which may be of interest:

No. 1—A young lady who spent last winter in Florida in order to try and secure relief from a very persistent cough. She has a family history of phthisis; she has been examined, however, by several physicians in the city who failed to find any evidence of tuberculosis; the sputum has never been examined. The cough recurred again this fall, and there was a sense of general discomfort about the throat. When she consulted me, on my first examination I was almost inclined to believe that there was no condition of the throat which could produce a cough. There was apparently no enlargement of the tonsils, there was little or no hyperesthesia of the parts, and she complained of very little trouble; but on pulling back the anterior palatine fold I found the tonsil was larger than it should be, and upon inserting a probe I found it the seat of the most intensely disagreeable odor, indicative of a septic condition. This patient came to my office two or three times per week for about six weeks, and was entirely relieved of all distressing symptoms and the persistent cough, under the use of the electro-puncture. This rather tedious treatment is really the objection to the electro-cautery; the patient has to be under the doctor's attention for such a prolonged period and make so many visits. The cough was evidently due to the deep-seated trouble in the tonsil, as there appeared to be no pulmonary trouble, and the cough has almost entirely disappeared.

No. 2.—Another case I happen to have just now has tonsils much like the one just reported. The patient has the most decidedly coated and offensive tongue that I have ever seen. He complains of pain and discomfort in the throat, not easily located at any one spot. He has consulted several physicians in this city, and has been treated for his throat by one or two gentlemen without very favorable result. When I began treating him I found he had some post-nasal inflammation, which was treated with the usual applications of carbolic acid, iodine and glycerine, and with cleansing sprays to the nose. On his next visit I detected some deep-seated tonsillar trouble, with intensely offensive, disagreeable odor. I have made very free application with electro-cautery to his tonsils, and when this source of sepsis is removed I believe the tongue will also clear up. Perhaps some of the general physicians present can tell us something about the relations of tonsils of this character to indigestion. Of course the connection between the throat and the stomach is a mutual one, each affecting the other. It is claimed by many authorities that tonsils of this nature are a very frequent cause of digestive troubles. This character of tonsil very often dips far up into the palatine arches, and is sometimes the seat of the disease upon which one of the members of this Society read a paper some time ago—the disease known as mycosis, which often involves the fourth tonsil and base of the tongue also.

In the use of the instrument under discussion, the number of punctures to be made at one time depends upon the extent of the trouble and the toleration on the part of the patient. I puncture two or three times at the first visit. I treat only one tonsil at a time.

As regards medicinal treatment of tonsillar affections like those referred to, I

do not think we accomplish much by local medication of any character. We all know how many medicines have been advocated for the reduction of tonsillar hypertrophy and for the removal of tonsillar inflammation. The saturated solution of chloride of zinc has not been effective in my hands. I have tried several, but so far cannot see that I have gotton any very positive results. Perhaps next to actual removal the application of strong antiseptic solutions, such as bichloride, carbolic acid, and, perhaps, chromic acid, would be most effective.

I think the drift, for the last few years, of specialists in throat diseases, as well as others who do work in this line, has been rather against the use of the tonsillitome in adults. At a recent meeting of the Medico-Chirurgical Society, I reported a case in which I removed the tonsils of a lady, æt 25, where secondary hemorrhage came on five or six hours afterward; not very severe, still enough to show how difficult such hemorrhages might be to control. Of course the complete removal of tonsils in children by use of the tonsillitome or knife, is the proper procedure, as the danger of hemorrhage is very slight; but in the adult, owing to the danger of hemorrhage, especially that of a secondary character, the tendency is toward the electro-puncture.

## NON-OPERATIVE TREATMENT OF SALPINGO-OVARITIS; ITS RESULTS AND LIMITATIONS.*

GEORGE ERETY SHOEMAKER, M. D.†

The value of the so-called conservative treatment of inflammations of the tubes and ovaries is a subject on which there is a wide difference of opinion among medical men; a large part of which difference arises from a misunderstanding of the cases to which it applies, and also from personal prejudice for or against operative treatment in this class of diseases. In the first place it is not always remembered that the highest permanent good of the patient is the object of all treatment; and the old adage, that what is one man's meat is another's poison, applies nowhere better than to cœliotomy in these cases.

The questions constantly presented for solution not only include those of degree of organic change, but the decision as to whether or not operative measures are to be used involves a careful consideration of an infinite number of circumstances in the life of the patient. For example, sterility, to some a curse, to others a blessing, to others a matter of indifference, is a very different question in the young and in the old; to the widow or to the mother of a large and struggling family. Again, a degree of disability, which can be readily borne by a woman of luxurious purse and indefinite opportunity to take care of herself, will ruin the life of one who must work or starve. It is sometimes asserted that the rich have as good a right to be free from pain as the poor. It may be answered that both have an inalienable right to an unmutilated body if this can be secured to them with fair comfort, and that this can be done for the rich in some cases where it cannot be done for the poor. There are important undercurrents, too, in domestic relations which cannot be ignored in the married, or in those who will afterward become so, as every close student of human nature must acknowledge.

It follows then, that in a given number of gynæcological cases, after we have selected the tumors, the major lacerations and the pus cases, aud have advised the knife, the only safe treatment for most of them, there will remain a still larger number who, besides being anæmic and possibly hysterical or hypochondriacal, or who may even be in good health otherwise, will present the condition named in our title, usually with a retroverted uterus, and often with more or less ovarian prolapse. The tubes and ovaries have at some time been inflamed possbily from eposure during menstruation, from an injury, or as a sequel to a general disease. This inflammation did not go on to pus formation, but left serious effects behind it; serious

*Read before the Obstetrical Society of Philadelphia, 1893.

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in their effect on the individual largely because of their persistence and their interference with a life of healthy activity. The patients complain of bearing down, pain in walking, dysmenorrhœa, the pain frequent preceding the flow, while numerous nerve symptoms depend more or less on the duration of the case, the degree of anæmia and the fibre of the individual. These patients have probably received a great deal of treatment, usually not systematically carried out by a specialist, they have been over cautioned not to exert themselves or "do too much," have become introspective and have long ago given up systematic exercise because it caused pain and was supposed to increase the trouble. They have become completely discouraged and often apply, or are sent by physicians, expecting to have their appendages removed.

Two questions must be answered for each case:

First. Will the woman be improved by the operation, and ought it to be done in her case?

Second. What are the prospects, temporary and permanent, of systematic non-operative treatment?

Let it be borne in mind that this discussion does not relate to appendages where no demonstrable disease exists. The question of operation does not arise here. None should be performed. I am in the habit of answering the first question, to begin with, that removal should not be done until other treatment, known to be carefully applied, has failed. Again, I am guided as to prognosis without operation by the amount of organized *adhesions,* and to some extent by the amount of prolapse of ovaries. A considerable experience of patient effort to release them leads to the conclusion that if the appendages are badly adherent and prolapsed, even though all soreness be removed by treatment and the patient be made comfortable, relapses are certain and frequent, and no definite progress toward real cure can be made from year to year. While periods of practical comfort, perhaps months in duration, may be secured by treatment, some exposure, some unwonted strain, as of household care or illness or one of the thousand and one depressing causes of ordinary life will put the patient where she was before. As a result of this experience, in a small proportion of the cases of salpingo-ovaritis which I see, where there is no reason to suspect pus, I counsel removal of the diseased organs. Especially is this done where adhesions are insurmountable, and where there seems to be valid ground for considering the lesions present to be the starting point of stubborn reflexes. In deciding the question as to whether or not adhesions are insurmountable, there is nothing so good as a patient trial by iodine or ichthyol, by boroglyceride tampons, by elastic wool packing and by careful stretching. I would not be misunderstood as meaning that these measures will have any appreciably effect on strong, well-organized adhesions. Such are too resistant to the fingers and too hard to separate after cœliotomy to allow such an opinion. Bowel, bladder, ureter or vein will tear long before some well-organized fibrous bands will give way. The point is that at a first examination, comparatively recent and therefore absorbable adhesions can not always be distinguished from more permanent ones, and under patient efforts to release continued, it may be for weeks or months, many an adherent fundus and adherent ovary or tube can be freed.

As before stated, I would decide to remove an appendage diseased in a lesser degree, if occuring in the mill worker, as compared with the woman of leisure. The struggle for an honest living is hard enough for the healthy; it is hopeless for her, who must lose many days of many weeks and be gradually so unstrung by pain as to lose her capacity for work in nervous invalidism. In other words, it is necessary in deciding these cases to understand fully the life, character, surroundings, work of each individual, and he who possesses the broadest knowledge of humanity will find help from all his knowledge.

Where the lesions are not so gross as to make the decision to operate imperative, there must be weighed against removal, beside the risk to life, which should be very small, the questions of contributing disease in eyes, throat and nose, nervous system or digestive system, conditions which may be practically irremediable. Well weighed, too, must be the possible abolition of sexual desire, with its curious psychical influences; the possibility of hernia in from 5 to 10 per cent. of cases

by old methods, the persistence of adhesions of bowel, bladder or omentum to stump or to cicatrix; the flushings and paræsthesiæ which group themselves about the monthly molimen, even though there be no flow. Though these points vary greatly in importance in different patients, no one who takes the trouble carefully to question patients who have had a section more than a year previously will ignore them. It has fallen to the lot of the writer to follow the fortunes of many who have been operated upon by himself and others, and to operate a second time on some of them. No operator can afford to belittle these points when it comes to the consideration of cases of the comparatively minor character under discussion. Of course, such points are far out-weighed in the presence of major lesions, which have been purposely excluded from consideration here.

## TRANSLATIONS.*

### A CASE OF TETANUS TREATED WITH SERUM.

Dr. Moritz, (*Munch Med. Wochen*, No. 30, 1893.) reports a patient, boy, aged twelve, developed a well-marked attack of tetanus in five to six days, i. e., jaws locked and extremities somewhat stiffened. The patient was admitted to the Polyclinic. The day following admission there was accelerated respiration, weak, compressible pulse, cyanosis, occasional delirium, moderate fever. Method and time of infection not clearly stated. Blood free from tetanus toxin.

On the eight day the patient received the first injection 50 ccm, Hehrings serum, (Heilserums) into each thigh. The pain and sleeplessness was combatted with chloral and morphia, 30 ccm., were given on the next day and 15 ccm., on the day following. Signs of improvement were slow in presenting themselves. Not until the last injection on the fifth day were any noticeable signs present. The head became more movable; the attacks of suffocation less often; the mouth could be opened somewhat; the cramps lessened in frequency and severity. The patient was considered cured between two to three weeks after the treatment had been instituted.

The author believes this desirable result to be entirely due to the use of the serum.

A discussion following the reading of this paper, gives us the opinions of a few others interested in this subject.

*v. Ranke* has used the same treatment in a boy aged 9, having used in divided doses, subcutaneously 60 ccm. of the serum. The boy was cured, and in this case there were no unpleasant symptoms, not even a rise in temperature.

*Buchner* suggested a more careful study of these isolated cases, particularly in relation to the action of the serum, as also, its early use.

The poison present with its attendant symptoms can not be removed by the serum. It is only possible to establish a condition of immunity, thereby preventing any further propagation, thus arresting any further destructive changes.

*v. Ziemssen* reported a case occurring in his practice, moderately grave in character. Bacteriological investigations, however, proved negative; other symptoms present distinctly those of tetanus.

He used 100 ccm. subcutaneously in divided doses, which were followed by decided local reactions. The patient recovered. v. Ziemssen, however, believes the patient would have recovered in spite of the injections.

*Brunner* expressed himself rather skeptically regarding the therapeutic use of the serum. A patient under his care, suffering from a grave attack, died in a short time in spite of its use.

*Moritz*, however, thought the serum had not been carefully prepared, nor had Brunner used it in sufficient quantities.

—W.

*Translated for The Medical and Surgical Reporter by the translators W. A. N. Dorland, M. D., and M. B. Werner, M. D.

## EXTIRPATION OF BRAIN TUMORS AND THEIR RESULTS.

Dr. V. Bramann says: The first case, that of a man, æt. forty-six, had received an injury to the head early in the year 1890. In October, 1891, there was some weakness in the left hand and changes in the muscles of the left half of the face. These were followed by clonic cramps of the left hand, arm and side of face. Consciousness was never impaired. This was followed by a paralysis of the left hand and left portion of the face. The operation was performed in December, after the method of Wagner. The temporary osteoplastic resection of the cranium in the region of the right side of the forehead and ascending frontal convolution was made. In this region a large, smooth cyst was found.

The microscopical examination of the extirpated dura and brain matter showed it to be a myxo-sarcoma with degenerated cysts. An increase of the convulsions produced the necessity for a second operation and was followed later by a third. After this latter the convulsions were cured. The paralysis gradually disappeared, as did also the slight appearance of a choked optic disc. Three months later all the symptoms had disappeared with the exception of a slight paralysis of the left hand and fore-arm.

Case 2. An intracranial brain tumor, weighing 280 g., occupying about two-fifths of that portion of the cerebral hemisphere. The patient recovered.

An artist, aged twenty-nine, suffered up to his eighteenth year from suppurating otitis media. In April, 1891, he had right sided pains in the head, accompanied by dizziness.

These were followed by three attacks, similar to apoplexy, leaving a weakness of the left hand and left half of the face. There was double vision, a marked diminution in sight, loss of memory, choked disc, more in the right than in the left, paresis of the left arm and leg, sensitive points on pressure in the right temporal region, twitching of the left half of the face. Trephining performed in May, exposing the lower half of the central convolutions, showing a tumor simulating a formation of an egg, 8 cm. long and 7 cm. wide. It was easily removed. Five weeks after the operation, consciousness returned, sight improving, and an improvement in the left sided hemi-parseis. The growth was a mixed spindle and round cell sarcoma. The appearance of choked disc and neuro-retinitis optica are constant symptoms where there exists much endo-cranial pressure.

In growths of the cerebellum we find, as a rule, those of the frontal and parietal lobes the most frequent—and those of the temporal region least often. If the tumor is located on one side the eye of the same side will be affected. In tumors of the cerebellum near the tentorium cerebelli, the choked optic disc will occur in both eyes at the same time.

Tumors located near the base of the frontal lobe often produce hemorrhages or ecchymoses of the retina. Occipital tumors near the tentorium cerebelli may give rise to choked disc on both sides; the intensity of the attack however may be unequal. In cases of tumors occurring at or near the temporal lobes, choked disc occurs more rarely (unless in the case of a rapidly growing one, abscess.) In the majority of such cases, it is present in both sides. Circumscribed tumors which displace the brain tissue will give rise to these changes more rapidly than the diffuse (abscess, etc.,) variety; should primary location, however, be near a sinus (sinus transversus) the latter variety will at once give rise to the grave symptoms described. *P. Allertoni* and *A. Brigatti*, also, report a case of a girl aged fifteen, who suffered since her tenth year from cortical epilepsy, always beginning with abnormal sensations in the left arm, passing to the left side of face and left leg, and at the same time twitchings were present. At first there was no loss of consciousness. At intervals there was great pain in the right frontal region, and a weakness of the left half of the body. There was left-sided hemi-paresis, particularly of the left hand, an increase of the tendon reflex, absence of the ankle clonus and there was moderate double choked disc. Diagnosis: glioma of the middle of the ascending frontal convolution.

September 12, 1891, removal of a tumor the size of a hen's egg.

Microscopical examination showed it to

be a fibro-glioma. Shortly after the operation there was still one attack, after that no more. A careful examination April 3, 1892, revealed an almost normal eye ground, diminution of the sensibility in the left half of the entire body, weakness and stiffness with increased reflex and ankle clonus in left arm and leg.

February, 1893, sensibility had improved. Some muscular atrophy had begun in the left arm and leg.

Of twelve cases of gliomas of the brain operated upon, in six the tumors was not reached until at the post mortem. Of the remaining six, five died usually about one day after the operation. The only cured case was that of *Horsley*, but even this was followed by a fatal return six months after. Of interest in all cases was the unanimous report of the disappearance of the choked disc after the extirpation of the glioma. —W.

## PRIMARY UNION OF A SEVERED END OF THE NOSE.

Dr. Hening, Halle, reports the patient, a student, having fought a duel, which resulted in a complete detachment of the end of the nose. The latter had to be searched for on the floor, and was found about twenty minutes later. It was carefully washed in a solution of ordinary table salt. It was then attached to its former seat with four sutures and bandaged with absorbent cotton saturated in the same solution. During the next twenty-four hours the wound was irrigated with the physiological solution of salt with but short intermissions. The temperature of the solution was kept at 37°.

The entire dressing was changed at the end of the third day. The flap was dark, having occasional red spots. No suppuration; dressed again the same as before, the dressing kept moist with salt solution.

On the sixth day dressing was again changed and the end of the nose began to appear red. The eight day removal of stitches showing primary union. Dressed with boric acid salve.

On the twelfth day the line of union still somewhat red. Otherwise condition excellent.—*Wünch Med. Woch.*, No. 43, 1893. —W.

## SACRAL DERMOIDS.

C. Gussenbauer, alluding to the lack of attention given to this subject in the general text books, has entered into a lengthy consideration in a clinical lecture.

Gussenbauer states that as long as the swelling or tumor is intact the diagnosis is easy; if, however, by some cause (injury, etc.), an inflammation arises which usually results in a fistulous tract, the diagnosis of a tubercular deposit in the sacral region is usually made.

Gusserow recognizes three characteristic symptoms, two of which are, as a rule, present.

1. The presence of one or two dimples situated in the median line toward the distal end of the inflamed swelling. These small depressions are caused by the dipping down of the epithelial layers. As a rule they end in a blind pouch, but may also communicate with a deep seated pus sac.

2. The presence of hair in the fistulous opening, or its appearance in the pus discharged from the sinus. These hairs usually resemble the lanugo and may readily be overlooked if the discharges are not carefully examined.

3. Microscopical examination of the pus usually shows, aside from the hairs and detritus, fatty or horny pavement epithelial cells.

In the presence of the above mentioned symptoms, or should only the last two be distinguishable, they are pathognomonic, and the diagnosis of sacral dermoid may readily be made.

The treatment of an intact tumor of this description is, simply careful and complete extirpation. In cases where fistulæ have formed, it becomes necessary to open the entire passage with the thermo-cautery, then curette the cyst walls, removing cyst walls and epithelium.—*Prag. Med. Woch.*, No. 36, 1893.

—W.

## CONSERVATIVE CÆSAREAN SECTION; THREE YEARS LATER PORRO ON THE SAME PATIENT.

Dr. Rühle, Elberfeld, presented at a medical meeting, held at the above mentioned place, the uterus of a patient aet. 30; third pregnancy; she had a contracted pelvis. The first operation, a conservative Cæsarean section, was performed by Sänger owing to the presence of cicatricial contractions along the vaginal canal. The first pregnancy having been terminated by craniotomy after some futile attempts at version and application of forceps.

The first Cæsarean section was successful in every particular, recovery prompt, the male child living, hearty and well. A drainage tube was passed through the cervix into the vagina in order to drain off the lochia. This opening closed entirely after some time.

The amputation (Porro's method) was performed on October 24th, 1893, before the onset of labor. The patient made a complete recovery, and the child, a girl, is living.

Examination of the uterus shows at the place where the former incision was made, a portion as thin as paper, which would have been the seat of rupture if the operation had not been performed before labor set in.—*Deuts. Med. Zeit.*, No. 98, 1893. —W.

## THERAPEUTIC SUGGESTIONS FROM FOREIGN JOURNALS *

### HEART DISEASE FROM DYSPEPSIA.

Dr. Bucquoi (*Medicinische Neuigkeiten*, No. 50, 1893) points out the value of a certain symptom in the differentiation of those heart affections which are dependent upon dyspepsia. In such patients there is usually a spot in the region of the area of cardiac dullness which is very sensitive to pressure and is situated in the fourth intercostal space. This sign will assure one that the cardiac affection is of dyspeptic origin, and that, by treatment of the gastric disease, the cardiac disturbance will yield. He recommends, in such cases, the use of Hoffmann's anodyne and nux vomica, in the following formula:

℞ Hoffmann's solution,
Tinct. nux vomica, ana,.....5 gms. (ʒj¼).
Ten to twenty drops a day, in a slowly increasing dose.

In order to combat the nervous diathesis which is usually present in these cases, he advises hydropathic measures. Every practitioner will meet, now and then, with cases which, though the patient complains of cardiac symptoms, the cause of their disease ought to be sought otherwhere. They suffer from all sorts of disagreeable symptoms in the precordium, a sense of constriction, dyspnœa, from slight exertion, etc. On careful examination of the heart, in spite of the most attentive search, nothing pathological can be discovered. The sounds are clear and percussion reveals nothing, yet one is not justified in accepting the existence of an organic heart affection nor of angina pectoris.

### PHOSPHATE OF SODA AS A PURGATIVE.

Prof. C. Paul (*Wiener Medizinische Presse*, No. 52, 1893) has employed the phosphate of soda for seven years as a purgative instead of the sulphate, ordinarily used. He prescribes it as follows:

℞ 1. Phosphate of soda.....25 gms. (ʒvj).
Distilled water.....200 " (ʒvjss).
Simple syrup..... 60 " (ʒij).
Alcoholic tinct. lemon .....gtts. xx.

2. Phosphate of Soda,..... 25 gms. (ʒvj).
Distilled Water,..... 250 gms.(ʒviij).
Simple Syrup,..... 60 gm.s(ʒij).
Alcoholic Tinc. of Lemons, .....gtts. xxv.
Citric Acid,
Bicarbonate of Soda, ana, 2gms. (grs.xxx).

About two hours after taking this purgative lemonade an evacuation will take place, which is soon followed by two others. Its action is easy and pleasant and it is taken with pleasure.

### OIL OF PEPPERMINT IN PULMONARY TUBERCULOSIS.

Dr. Carasso (*Deutsche Medicinische Wochenschrift*, No. 49, 1893) publishes a new method of treating consumption with which he claims to have obtained brilliant.

* Translated for THE MEDICAL AND SURGICAL REPORTER by F. H. Pritchard, M. D.

results. It consist in the continuous inhalation of the oil of peppermint, with the internal administration of an alcoholic solution of creasote and chloroform to which one per cent. of oil of peppermint is added. The results were remarkable for, not only were cases cured in the first stage, but also those where there were extensive cavities and numerous bacilli in the expectoration. The cough and expectoration diminish, the appetite reawakens with a considerable increase, in weight, with the growing appetite. Gradually that portion of the lungs affected assumes a normal condition and vesicular breathing reappears. Hence a complete restoration of the diseased tissues to the normal may be assumed to be possible. If the pulmonary affection is associated with fever, it will disappear in a few days. These remarkable results were obtained in no less than thirty-nine cases of actual consumption, in every stage, yet only when it was limited to the lungs and not when other organs were envolved. Braddon has demonstrated that peppermint exercises a bactericidal action and he has also gotten good results with inhalations of peppermint, in phthisis.

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### SALOL IN PHTHISIS FLORIDA.

Dr. A. Lutz (*Fortschritte Der Medicin*, No. 23, 1893) heartily recommends the methodic use of salol, in florid consumption, from an experience extending over two years. The daily dose was, chiefly, six grams (one and a half drachms), administered in capsules. The fever and night sweats decreased gradually and disappear in a few days to one or two weeks.

The profuse sputum is decreased and the cough diminshed. It will often aid even in desparate cases to prolong life.

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### DIGITALIS IN FROST-BITES.

Dr. Pilatte (*La Semaine Médicale*, No. 72, 1893,) advises looking to the general circulation in the treatment of frost-bites. They are firstly and chiefly due to a disturbance of the circulation in general, it being a paralysis of the vaso-constrictors from cold. Sanguinary stasis induces partial mortification of the tissues or the formation of fissures and ulcers, this being principally due to a weakness of the cardiac contractions. In those with frost-bites there is a diminution of arterial tension with peripheric vaso-dilation. The mech, anism of this resembles that of Raynaud's disease. Besides treating the basic diathesis—rheumatism, scrophulosis, tuberculosis, etc.—he advises frictions with a hair glove, often preceeded with a cold effusion or douche of short duration. If there be an organic or functional deficiency of the heart then give digitalis, prescribing every week, for two days, seven to twenty-two grains of digitalis leaves, in maceration, caffeine or kola. This former drug yields a remarkable result even in cases where it is not indicated by the condition of the heart It also acts well locally, but then a stronger preparation should be used. Keep the feet and hands perfectly clean, the hands scrupuously dried after washing, and follow with a stimulating friction with eau de cologne or camphorated alcohol. To prevent ulceration or the formation of fissures, use antiseptics locally. Locally, he has obtained the best results with the following formula:

℞ Tinct. digitalis..... 6 gms. (℥ss).
Crystalized Thymol..... 5 (grs. xlv).
A'cohol .. ..... (70 per cent.).
Glycerine.....ää.... 150 (℥ivss).

In case of severe itching apply locally the tincture of iodine, every three to four days. Fatty substances and vaseline are to be avoided while gloves and warm baths are more harmful than useful.

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### SCARLATINA IN CHILDREN.

Dr. A. Correa (*La Semaine Medicale*, No. 72, 1893) praises in scarlatina of children, the following:

℞ Nitrate of pilocarpine..... 3 gms. (grs. xlv).
Aconotine.....3 gms. (1–20 gr.).
Salicylate of soda.....¾ gms. (grs. xlv–℥j).
Alcohol,
Syrup of orange peel, aa...15 gms. (℥iv).
Distilled water.....120 gms. (℥iv).

A teaspoonful every twenty minutes, until the usual effects of pilocarpine are noticed. As soon as this action disappears then commence its administration again. He claims that under the influence of this method of treatment the disease, even in case that it be malignant or associated with pultaceous angina, assumes a benign character.

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### ICE IN ASTHMA

Dr. Sangee (*La Semaine Médicale*, No. 72, 1893) in a violent seizure of bronchial asthma where all the usual remedies were powerless to abort the spasm, succeeded in relieving the attack by local application

of ice to the neck, along the course of the pneumogastric. Five minutes after its application the asthma disappeared entirely and the patient fell asleep, for the first time, after four nights of complete sleeplessness. At the end of several hours he was awakened by the sensation of severe cold produced by the ice. It was then removed and replaced by compresses, under which influence the last symptoms disappeared entirely.

### CORYZA.

Dr. Grellety (*La Semaine Médicale*, No. 72, 1893) speaks highly of the following formula, in the treatment of coryza:

℞ Betol, 2.50 gms..... (grs. xxxviij)
Menthol. 25 cgms..... (grs. iv)
Muriate of cocaine 15..... (grs. ijss)
Powdered roasted coffee, 1. 50 gms. (grs. xxij)

This should be finely pulverized and passed through a fine seive.

### GLYCERINE IN GRAVEL.

Dr. Heymann (*Revista de Ciencias Medicas de Barcelona*, No. 24, 1893) has employed glycerine in renal lithiasis, on account of its property of dissolving uric acid and also passing unaltered through the kidneys. He records fourteen cases treated by this method. He summarizes his impressions as follows:

The first effect of its ingestion is to increase the thirst. In those suffering from stone in the kidneys, pains appeared in this region, it being limited to the one side affected. The quantity of urine was increased, and, after a varying time of nine to twenty-four hours, small calculi were expelled. In ten out of these fourteen cases he obtained favorable results. The pains were not as severe as those of renal colic while the urine, after its ingestion contained neither albumen, sugar nor hemoglobin. Even after three to four hours the presence of glycerine could be discovered in the urine, in appreciable quantities. A large quantity of mucus was also noticed. Based upon these results he regards glycerine as the most efficient means of treating renal lithiasis.

### BICARBONATE OF SODA IN DIABETIC COMA.

Prof. Huchard (*Revista de Ciencias Médicas de Barcelona*, No. 24, 1893.) calls attention to the value of the bicarbonate of soda, in large doses, in the treatment of diabetic coma. The precursory symptoms somnolence, dyspnœa, and muscular weakness, all disappear within a week, if one administer increasing doses of the bicarbonate thirty to forty-five grams, an ounce to an ounce and-a-half, per diem. He cites a case, treated in this manner, which confirms the value of this method. The vertigo, mental depression, anuria, disappeared in forty-eight hours after the administration of twenty grams, five drachms, of this salt. Although the hypodermic use of alkalies has not given good results in the treatment of acetonnuria he thinks that the opportune employment of the bicarbonate, during the prodromal period, to be a precious addition to our treatment of diabetes.

### DIARRHŒA OF DENTITION.

In the (*Ciencias Médicas de Barcelona*, No. 24, 1893), in the treatment of the diarrhœa of dentition, the following preparation is found of use.

℞ Subnitrate of Bismuth.....4 gms. (ʒj.)
Lime water.....8 " (ʒij.)
Fennel water.....100 " ʒiijss)
Syrup of Orange Peel.....20 " (ʒv.)

One teaspoonful every three hours.

### FETID DIARRHŒA IN CHILDREN.

Dr. E. Tompkins (*La Semaine Medicale*, No. 73, 1893) speaks highly of the following, in the fetid diarrhœa of children as an intestinal antiseptica.

Calomel ..... 10 cgms. (grs. jss).
Sulpho-carboate of Zinc..15 " (grs. ijss)
Subnitrate of Bismuth.. 8 gms. (ʒij).
Pepsin..... 2 " (grs. xxx).

Sufficient for twelve powders. Three per diem, in a child of one year.

### ABSORPTION OF SALICYLIC ACID BY THE SKIN AND ITS USE IN ACUTE RHEUMATISM.

Dr. Bourget (*Revista de Ciencias Médicas de Barcelona*, No. 24, 1893) concludes as follows:

I. Absorption of salicylic acid by the skin is very rapid and intense. The skin of youthful individuals is most absorbent while persons with white skins are more so than those with brown or black. The rapidity and intensity of its action are dependent upon the vehicle in which the acid is dissolved. Fatty substances greatly facilitate its penetration through the skin while with glycerine or vaseline it is less. Treatment of acute articular rheumatism with a salve of salicylic acid and turpentine is to be recommended. It is less serviceable in other forms of rheumatism though it might be of value as an adjunct in massage. In gonorrhœal rheumatism it is inactive.

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SATURDAY, FEBRUARY 3, 1894.

## EDITORIAL.

### A WISE PROPOSAL.

Evidently anticipating its opportunity, the *Medical News* denounces "The Star System of Medical Education" and urges radical changes in the organization of medical faculties. It believes that "the organized and vivified medical college is to take the place of the cluster of individual medical star-professors of the past—that personalities are to be subordinated to a system, leading rôles to be merged into a harmonious unity, men into an institution. A great work is to be done, a work requiring a large number of specialized workers, each performing his peculiar function, each the equal of the other, and all running to a unity of result that leaves no place for exaggerating one or two rôles, while extinguishing all others. It is clear, therefore, that the college which soonest and best meets the new ideal will be the college of the future, and the college that clings to the methods of the past, seeking a few leading actors and cruelly silencing subordinates—with necessarily resulting jealousies and self-seekings—must assuredly go down. Such a college as this last inevitably becomes ring-ruled, the financial aspect ever uppermost, never willingly lengthening the course or raising the entrance standard."

It concludes its attack on the present order of things as follows:

"This new tendency, nay, this coming and pressing necessity, does not in the least extinguish individuality, but leads to its healthy development. It was the old plan that with ruthless barbarity throttled all individuality except the egregiously selfish individuality of the star, and that smothered nascent ambition and possible teaching ability in order not to permit rivalry. The new plan, with its enormous increase in numbers of the teaching body of a college, encourages the healthy growth of individuality and of special ability. But it does one other most important thing: it reduces to useful subordination all egotistic advertisers and self-seekers, and binds individualities together for a work and a system that outlasts and is of more importance than individuals."

We do not understand that the new dispensation advocated, contemplates the utter extinction of stars of the first magnitude in order that the glimmerings of the milky way may become manifest, but rather the turning down of those flickering gas-jets which, intruding in the field of vision, obscure all other lights, and which in certain conditions of mental fogginess, have been frequently miscalled 'stars.'

It means the suppression of 'stars' which in reality are only reflectors of light gathered from extraneous sources, which sources are studiously concealed from the public view. It intends the abolition of 'professors,' whose greatness consists in an unlimited capacity for *unconsciously assimilating* the ideas of modest thinkers and, *consciously* ignoring the sources of their ideas, promulgating them as their own. It means the sequestration of authors and authorities who buy the work of starving brains and publish it over their own names.

In all branches of science reputations obtained by furtive means are numerous —and evanescent. It is the elimination of such 'stars' that is proposed and the substitution therefor of a galaxy of fixed stars, each occupying its own place and shining by its own inherent light. All acting in harmony, to constitute a constellation which when sought for can always be found, and which affords a basis for accurate calculations.

Coming down from the clouds, this means that the faculty of a medical college should be made up of *teachers* thoroughly acquainted with the subjects which they are to teach and capable of imparting their knowledge to others. It means that these men should be afforded every facility for conveniently prosecuting their studies. It means that they should make the interests of the institution their own, and should not subordinate the institution to any outside interests. It means that these teachers should be secure in their positions so long as they perform efficient work. It means that they should be allowed to think for themselves and to have the freedom of speech. It means that each should be the peer of the others, and that the will of the majority should determine the policy. It may mean a good deal more on these lines, but in effect it presents one side only of the question.

The *Medical Record*, commenting on this article in its usual light-hearted manner, tersely presents the other side. It says:—"There is no doubt that too many medical men become "professors" from purely selfish motives, such as building up a consultation practice, or posing as "eminent authorities" before the laity. On the other hand, unless "professorships" are made attractive and profitable, the best talent will not be eager to enter the charmed circle of professorial dignity. Human nature is not materially altered by the possession of a medical diploma. Unless professorships "bring in" something tangible, only mediocrity will stampede toward the empty honors of the college chair. Good men demand good rewards in this matter-of-fact world. Emoluments are just as attractive to doctors as they are to lawyers, or to clergymen, or to plain every-day business men. The professor of the future may not care about sordid details of compensation for his work. But we take it that that kind of professor is a dim and nebulous hypothesis, whose chair is not planted on terra firma. A flesh and blood professor needs his three meals a day, just like ordinary mortals. And we believe, in most instances, he deserves them."

In other words, secure the best teachers, appreciate their value and pay for their services. Services that can be obtained for nothing are worth less than the price paid for them.

It will be noticed that there exists a distinction with marked differences between *teachers* and *professors*.

## RESPECTFULLY DECLINED.

The *Record* concludes its comment on the preceding article with an exhibition of disingenuous generosity that is awe inspiring.

"If they really need more professors over there in Philadelphia, we might, on a pinch, let them have a few of our own. A famine of professors is not what we are seriously threatened with at present in New York."

More professors!" Angels and Ministers of Grace defend us!" If by the most violent squeezing a few efficient *teachers* can be extracted over there, Philadelphia can furnish them a field for work and contemplate the gift with equanimity. But as the lack of such material is much more painfully evident in New York than here, we must respectfully and firmly decline to have any more "professors" unloaded on us. However glad to accommodate friends, Philadelphia must enforce the first law of nature.

So far from there being in this city any lack of 'professors,' our factories annually produce more men with professional qualifications and aspirations (as can be certified by every member of their immediate families, relatives by blood or marriage, or any socially connected with them, their domestics, employees or clubmates) than the entire number of professorships existing in the United States. What Philadelphia does lack is cold storage facilities for the safe keeping of 'professors' for the benefit of posterity.

Efforts have been made to meet the conditions, but the problem appears to be similar to the social question of the treatment of the unemployed, but on a much reduced scale. Some institutions have experimented by taking a "chair," none too large for a single teacher, dividing it, and constructing two or more high chairs suitable for *professors*, imposing a high tariff for revenue and installing the most needy applicants.

The results of such speculations appear to have been more for edification and less for education. The cost of chairs seems to have grown beyond the reach of private resources, and now require a subsidy from the government to maintain them. Indeed, it looks as though 'professors' would soon require a congressional appropriation (either under a River and Harbor bill, or a deficiency appropriation) to secure an opportunity for letting men see their light shine. 'Professors' are too numerous and chairs cost too much, and we don't want them anyhow, but for higher medical education and the progress of medicine, we do want more efficient *teachers*, and we wish to see them paid for the value of their brain-work and not for ability to make excerpts from the ancient chronicles of medicine.

### Creasote in Chronic Pyelo-Nephritis.*

Dr. Weber (*La Semaine Medicale*, No. 72, 1893) has found creasote of value in the management chronic pyelo-nephritis. In this disease, consecutive to renal lithiasis, gonorhœa or other infectious disease the condition of the patient is often very grave and frequently incurable, for, as in pulmonary tuberculosis there is a progressive exhaustion. In certain cases surgical measures as nephrectomy or nephrotomy may render efficient aid but it often happens that these very operations are impractical, as for example, when the hydronephrosis is bilateral, the patient is either too aged, too weak or refuses an operation. The usual medical treatment is generally quite unsatisfactory. Creasote administered, internally, for a long time and, in large doses, will yield favorable results. In four cases, treated thus, he has obtained a distinct and lasting amelioration, after a few months of treatment. The attacks of fever, together with the painfulness, in the region of the kidneys, disappeared, micturition became clearer and continued less and the patients felt well, while there appetite increased together with their weight. He administered the remedy either by the mouth or rectum in injections or suppositories—in doses of three to five drops, three times a day.

* Translated by F. H. Pritchard, M. D.

# ABSTRACTS.

## THE PHYSICIAN AND THE PHARMACIST.

In a paper read in the Section on Materia Medica and Pharmacy of the American Medical Association. Dr. L. Ch. Boisliniere says: A few words of protest and advice are herein offered from an old practitioner. I believe in the profession of pharmacy and I highly respect the pharmacists. They are the hand-maids of the physicians and our best friends, often our useful advisers. The two professions should work in harmony, one not encroaching upon the specialty of the other. Therefore the pharmacist should not tolerate any counter-prescribing, and the physician should not dispense his own medicines. I therefore most strongly protest against the custom, lately too frequently resorted to by physicians, of distributing among their patients any of the potent triturates, or dosimetric granules, so elegantly put upon the market by otherwise reliable wholesale dealers. This practice is enticing, but it is often dangerous.

This protest applies chiefly to the city physicians; an exception should be made in favor of the country practitioners. For them it may be sometimes absolutely necessary and is often very convenient; they are so placed that they can not do otherwise; but it is a practice fraught with danger.

This practice, in cities especially, may be followed by suits for malpractice in case of any accident. The prescriptions on file with the pharmacist are a strong protection to the physician, as they can be referred to, and, if necessary, brought into court in case of a suit for damages. While serving as coroner of St. Louis county, several cases of this kind came under my official notice for investigation. One was the case of a woman, for whom a most reputable physician had prescribed a mild cough mixture. The husband, at the inquest, stated that his wife walked in the garden, after taking a teaspoonful of the medicine, and dropped dead, as if shot. Happily, the bottle of medicine was in the house, properly numbered, and came from a very good pharmacist. The prescription from the file was brought to the house of the deceased and shown to the jury to be a harmless mixture. This, however, did not entirely satisfy the husband. In order to convince him, I opened the deceased's chest and showed him the heart; the pericardium was enormously distended; puncturing it, I received in a cup nearly a pint of serum. The woman had died of acute pericarditis. This amount of serum, pressing on the heart, had caused its sudden stoppage and the patient's death. The husband was satisfied and the physician discharged.

Upon another occasion, an old man had had a weak solution of morphia prescribed for nervousness. The next day I called at the house and found the front parlor full of people and crape at the door. On my inquiring about the patient his sister rushed in, in a fury, and exclaimed to me: "You dare inquire about my brother! You killed him! He walked to the mantelpiece, took a teaspoonful of your infernal mixture and dropped dead!" He died of paralysis of the heart, as was afterwards ascertained. The pharmacist, an excellent one, was requested to come immediately with the prescription, which he had on file, and which called for one grain of sulphate of morphia, of which the patient had taken one teaspoonful, equivalent to one-eighth of a grain, which certainly is not a poisonous dose. The family was finally satisfied that the fatal result was not connected with the medicine.

From these cases is seen the great advantage of filing, dating and numbering prescriptions.

In another instance, there was prescribed for a young woman a one-eighth grain dose of morphia; but, through the accidental misplacement of the bottle, she took one teaspoonful of strong sulphuric acid, and would have died had it not been for copious draughts of water, mixed with plaster scraped from the walls of the room. For several months, she could swallow nothing but milk, as she had an extensive inflammatory stricture of the esophagus.

Here the pharmacist was called in to show that the prescribed mixture was a weak solution of morphia and not sulphuric acid, which it was subsequently learned had been left carelessly in the room to acidulate a battery. I could relate more cases, but these are sufficient to illustrate my position, that often the pharmacist is the best protector of the physician.

Another point to be considered is this: Quite a reprehensible custom is that of pharmacists, on demand of patients or their friends, repeating prescriptions without the order of the physician. This is done generally because it would be impolite to refuse; moreover, they have nothing to gain by it. This indefinite refilling of prescriptions should not be done, because it makes the patient his own prescriber, often to his own detriment, as no two patients or diseases are alike. It is a dangerous practice, and should be abolished by a mutual agreement with the pharmacists. This practice is often resorted to by designing persons for mercenary purposes. I will briefly recite a case to illustrate:

I once prescribed a mild but efficient cough mixture. What was my amazement when I ascertained that the formula had been printed and sold to many acquaintances for twenty-five cents a copy. Let, then, physicians and pharmacists live in perfect harmony, following their useful and noble professions, each respecting and protecting the other. — *Jr. A. M. A.*

## THE SUCCESSFUL MANAGEMENT OF INEBRIETY WITHOUT SECRECY IN THERAPEUTICS.

Dr. C H. Hughes, (*The Alienists and Neurlogist,* January, 1894,) writes: Dr. Benjamin Rush, in his "Diseases of the Mind," published in 1812, recommends, "The establishment of a hospital in every city and town in the United States for the exclusive reception of hard drinkers" and says "they are as much objects of public humanity and charity as mad people; and religious, moral and physical remedies * * * should be employed * * * for the complete and radical cure of their disease."

Since the immortal Rush rested from his labors, vast progress has been made, and vaster still is making in the management of the drink habit, and in the treatment of the drink disease. Facts which, but a few years ago advanced observers, like Morel, Magnan and the few neurologists of their time, first took note of, touching the hereditary transmission of neuropathic instability and dipsomaniacal tendencies through ancestral alcoholic excesses and *vice versa,* have not only passed into the possession of the profession generally as practical knowledge, but have become largely the mental possession of the people. The profession, the people, and even the unfortunate victim of the drink habit himself, have come to the understanding that habitual resistless inebriety is a disease and chiefly of the brain and nerves, and under this impression, resulting from medical research and teaching, the drunkard and the dipsomaniac now seek and the profession now give, medical relief to the sufferer, or the friends of the inebriate procure this relief for him.

The general professional consent and popular recognition of the fact that inebriety is a disease, are the results of the impressive and persistent efforts of the British and American Associations and other medical societies having in view the cure of inebriety.

In the general recognition of the fact of the disease basis and remedial possibilities respecting the baneful, morbid vice of the man's nervous system, we are hopeful of such an inestimable physical and moral fruition as must ultimately result in marked national re-invigoration, and in the postponement, at least, of national degeneracy impending through this, as one of the causes of racial decline.

We know now how to successfully scaffold and prop, and steady the tottering nervous structure of an inebriate neuropath, and sustain it in fairly normal function pending its effectual reconstruction, and we know how to permanently rebuild this damaged nervous system, through the advances neurology has made during the life of the present generation of physicians,

though, alas, we cannot always remove the baneful neuropathic entailments of chronic alcholism upon the immediately succeeding generations of the drunkard, while we may and do, do much to ameliorate, modify and ward off the baneful neurotic *sequelæ*.

The unchecked degeneration of whole families through generations of neuropathic descent, such as Morel and others have presented, as the frightful admonitions of scientific research against the fatal neural and psychoneural degeneracy of alcoholic excess, are not possible under the skillful management of modern medical art as now practiced, especially in the neurological department of medical work.

It may profit us at this juncture to recur again (as mentally we often do to similar personal observations) to one of Morel's typical tables illustrative of the course of alcoholic neuropathic degeneration unassisted by our art, and I take this table from our classical and observant *confrere* across the ocean, Dr. Henry Maudsley, because the interesting researches of Morel into the formation of degenerate or morbid varities of the human race have served to furnish to the physiological mind of this distinguished neurophysiologist, as it has to you and me, a philosophical view of the chain of events by which alcoholism as a cause of individual degeneracy continues its morbid action through generations and finally issues, when unchecked by the arts of our profession, in extinction of the family.

First generation.—Immorality, alcoholic excess, brutal degradation.

Second generation.—Hereditary drunkenness, maniacal attacks, general paralysis.

Third generation.—Sobriety, hypochondria, Lypemania, systematic mania, homicidal tendencies.

Fourth generation.—Feeble intelligence, stupidity, first attack of mania at sixteen, transition to complete idiocy and probable extinction of family.

How many painfully impressive pictures like this have we not seen in our several spheres of observation and practice, and how many impending family calamities like this are now avertible through the resources of medicine and philanthropy which our present advanced neurology offers the neuropathically unstable? It is a source of professional congratulation that the medical profession, and especially our department of professional endeavor, has brought relief to the inebriate, and mitigation with the hope of ultimate extinction of its entailed neuropathic evils to the human family, if only we are permitted to treat this disease as its pathology demands, and an enlightened public sentiment promises this as the consummation of our professional labors and hopes in behalf of man's highest and best interests for the closing of the Nineteenth Century.

The profession and the public believe that inebriety is a disease. They now believe that it can be successfully treated, and that it ought to be treated, not only for the good of the inebriate, but for the welfare of his descendants. They have now the knowledge that precedes wise action.

Drunkenness is unpopular; inebriety is on the decline; dipsomania is dangerous to the drunkard's descendants, as well as detrimental to himself.

Medicine has given to the world the substantial basis of a new reformation. It has sounded the alarm; it offers the remedy, and, on this score, we think humanity is on the road to safety.

This is one of the jewels we place in the crown of the Nineteenth Century progress. We give it freely to the cause we crown without copyright, letters patent or secret process.

With the diffusion of knowledge among the people and their advisers, the general profession, and especially the family doctor, that alcoholism and dipsomania are grave diseases, with graver physical and psychical *sequelæ*, hope has dawned for the drunkard, and the prospect of the final obliteration of inebriety and its terrible evils to the individual, the family and the state, brightens. Henceforth, the unfortunate victim of alcohol is to be cured and then reformed through the seeking of medical relief, and such as are not confirmed in baneful habits of intemperance will turn in time from the social tempter, and avoid the neuropathic thraldom of this devil's chain of evil tyranny.

Many men who fall into the drink habit are unaware of the terrible neuropathic heritage of unsteady nervous organism bequeathed through bibulosity and other nerve depressing influences operating on their ancestors. They know but little of the organic evils and entailments of alco-

hol. They know chiefly physical, moral and social discomforts and inconveniences of getting drunk, which are as nothing compared with the damage to their brains, nervous systems, blood-vessels and vital organs.

Not understanding the tyranny of their unstable nervous system they censure themselves as fools for each repetition of a bout of drinking and resolve and re-resolve not to do it again, then go on and die the same, in the majority of instances, unless aided by medical art to overcome the otherwise resistless tyranny of a viciously endowed organism, which impels to the fate they dread without the power to draw away from it, yet thinking each time they drink it will be the last.

The trouble in the past about this blended vice and disease has been in the failure to seek, by suitable change of environment and proper medical treatment, that renovation and rebuilding of the damaged organism which makes resistance to alcoholic enslavement a possibility in the organism of the average habitual or periodic inebriate. That profession which has rescued mankind from so many portentous evils after other resources have failed, is ready to succor him now from the thraldom of damaged organism and psychical weakness and neuropathic instability.

We need not now go deeply into the pathology of chronic alcoholism, but cursorily glancing at the subject we have only so recall the findings of Virchow, Richardton, Horsley, Percy and Binz, of water decreased and fibrine changes in the blood, sometimes quite fluid, at others, coagulated, pure alcohol in the tissues, fatty globules in the circulation, fibrinous clots and excrescences in the vessels, vascular dilations, anæmia, deficient hæmoglobin, of old and excessive alcoholics.

Nor need we dwell upon other destructive and degenerative changes, which, like the annihilated phagocytes of alcoholized persons to which their well-known lack of resistence to general morbific influences is due, are secondary to the poison. We have to treat these conditions as *sequelæ*. This fact and the other prominent fact that alcohol abstracts fluid from the tissues of an organism whose very nerve cell is bathed in lymph, whose cerebro-spinal axis, as Obersteiner tells us, lies in a sea of lymph, an organism to which water is the *sine qua non* of life, give us the chart and compass of our course; and the polar star is the care and cure of the damaged brain, the brain and associate spinal and ganglionic system from whence originates the illusions, the hallucinations, delusions, anæsthesias, paræsthesias, hyperæthesias and hyperalgæsias or the peculiar polyæsthesias of these cases. All of these sensory troubles, together with the well-known motor symptoms, the motor paresis, muscular tremor, twitchings and inco-ordination, the *paresis* of the cortical areas of the brain, where the volitions center and whence they proceed, impaired and vitiated, in the drunkard. To these and other symptoms which go to make up what Bevan Lewis designates as the motor anomalies of an alcoholic etiology and all the psychical symptomatology, which this writer and Huss and Magnan and Maudsley, Usher, Wilson and many others describe, give us adequate outline of the detail work necessary for the thorough and permanent cure of the inebriate. He will be largely made over and made whole. No three weeks' treatment will suffice. We may break him for the time of his habit in three weeks and yet leave him a wreck for life. Our duty is to repair him and make him anew if he will permit us to do it. We cannot ignore the protean nature of alcoholic symptomatology or forget the fact in our treatment of this disease that no poison except the virus of syphilis plays so extensive a *role* in the morbid affections and degenerations of the tissues, nervous or non-nervous, as alcohol.

When illustrated chapters in the pathological anatomy of alcoholism, especially like those in Bevan Lewis' recent textbook on "Mental Diseases," are so readily accessible, and when, besides, the cultured character of my distinguished auditors is considered, it is obviously unneccessary to dwell in detail on the pathology of alcoholism. I could not enlighten you—you would rather enlighten me on the subject.

The point of this paper is psychcial assistance and neurotic support, and neurotic and organic reconstruction. We must first secure the man's safety from the thraldom of drink and repair the secondary damage later. We must first put out the fire and save what remains of the still standing structure, prop the weakened walls, and then rebuild and re-

move the damages. The foundation and framework of all reconstruction of the drink-damaged dipsomaniac is in the nervous system. If we can rescue that from immediate and ancestral damage, we can save the man, but we must not leave him, after our treatment, damaged and shattered in his brain or nerves or blood or vital organs. We must make him strong and resistive in the higher inhibitory volition and directing realms of the cerebral cortex and restore the normal functions within and presided over by the lower cerebro-spinal and ganglionic centres.

It is obvious that in attempting to effectually and permanently cure and reform the inebriate we undertake a large contract, one that cannot be fully complied with in the brief space of a few weeks. When we have broken the chain of morbid habit there yet devolves upon us the duty of after-care that the victim's health may not be permanently shattered, and that insanity and other evils may not follow.

*The first* essential to the cure of inebriety is the substitution of a less harmful support to the shattered brain, nerves and damaged vital organs, than alcohol, and I name them in their order of preference. The morphias or opium, strychnia, the quinias and cinchonias, valerianates, cocas, the ammonium bromide, etc., etc.

*The second* and concomitant essential is water—plenty of water or its equivalent, milk. The tissue must have water, the blood must have it, the emunctories and the skin must have it.

*The third* and concomitant essential is rest. Normal nature tired prescribes it for every bodily or mental overtax. Exhausted abnormal nature always needs it and demands it often. The machinery of the human orgamism in all its parts—psychical or physical—must be put at rest for the best repair.

The chief essential for rest is a new and proper environment, and subsidiary to this are the chemical restraints therapeutics may place on over-acting cells; chloral, sulphonal, the bromides, the vegetable narcotics, old and new, the valerianates, the opiates, cephalic galvanization, and soothing music and the bath.

*The fourth essential* is the removal of the *debris* of the last and previous drunks, and of the interim of organic torpidity and depressed vitality. The scavenger cells, diminished in number or absent as they are in *toto* from the blood, and the emunctories have failed in their physiologically appointed work; the congested brain, liver, stomach, intestinal tract, mucous membranes generally, torpid liver, bowels and skin, are to be relieved and set at their proper work again.

Here, water, saline laxative water without stint, is the remedy *par excellence*. It flushes the intestinal tract and the excreting organs. Nature suggests it first of all after the rest she enforces after a prostrating spree.

I need not here dwell on the proper therapeutic blendings for this hydrotherapy to give more special direction to liver, kidneys, skin or bowels.

My preference is for an effervescent salines that clears out the alimentary tract and tranquillizes the brain and nerves at the same time (though mercurials are often not amiss), and then to properly start all the pumps of the system that may not be acting well and maintain them in moderate activity till there remains no pathological clogging of the wheels of physiological activity, but I do not approve of over-active catharsis. Moderation and not violence in this regard is my motto.

The *fifth* and concomitant essential is reconstruction of the undoubtedly damaged cerebro-spinal centers and the several affected organs of vegetative life. A drunkard is more or less damaged in many parts of his anatomy at the same time. He comes more nearly to being affected all over in spots than most patients we have to treat.

We begin reconstruction with the beginning of treatment. It begins with rest and sleep and food and change of surroundings, when Nature, without further aid, can effect it, rest, nutrition and phosphates, the hypophosphates and the reconstructive hæmatics and other rebuilders of the blood. Milk, beef-tea and capsicum and other stomachics. Early in the treatment a hair of the dog that bit him—a milk-punch or egg-nog, egg phosphates flavored with wine or whiskey, the latter soon withdrawn. In this stage the wines of coca, the beef, wine, iron and strychnine compounds, calisaya cordials, egg phosphates and stimulant tonics, are temporarily admissible.

When the patient is cured of his recent attack of delirium tremens, or recuperated from his last debauch, then the hypodermic medication that is to hold him from further relapse, to re-tone his system and break him of his taste, must be instituted, if we have not begun it sooner.

*The sixth* and final essential, to which all our previous efforts lead us, is destruction of the drink craving, and this is done on physiological principles. The drink craving is pathological perversion of physiological cell action, and lies in the realm of the cerebral cortex. This part of our subject belongs to psychiatry and psychical suggestion, effected by a therapy directed to these morbidly acting centers of the brain, accomplishes our purpose. When the drink craving comes on, having in the meantime rebuilt the shattered brain and nervous system and restored the mental tone as much as possible, we do not absolutely inhibit the use of the accustomed drink, but train the drink victim's own inhibitions, first, by suggestion; second, by moderate indulgence properly treated.

We do not say, "You shall not, but you had better not drink. You know it is poison to you and you are its slave. You should resist. Your treatment has made you strong. You *can* resist. Whiskey no longer tastes as good to you. You no longer need it. You have the power now and should assert your manhood," and with these suggestions, perhaps the victim will try the liquor, we give him *spiritus frumenti* f℥ij, *cum vini antimonii*, f℥i, and repeat *ad libitum*, or we have previously given him apomorphia with aurum bichloride for psychical effect. Under this or similar management of the appetite, the victim acquires a disgust for his favorite drink, he discovers his inhibition of the propensity is strengthened, and a disgust supplants the taste, which abides till he is fully restored in nerve tone and power to permanently resist and assert his manhood and maintain it against all future assaults of the foe.

As I cannot, in the brief time allowed, further detail my plan of treatment, this outline must suffice, with the promise in another communication of special prescriptions and combinations, embodying the plan of treatment here outlined, and which has proven successful in desperate cases.

After your patient is cured, after the toxic effects of alcohol have gone from the blood, and the higher and lower nerve centres and the damaged tissues of the body have regained their normal nutrition, powers of assimilation, and strength of physiological action and resistance; after confidence in his strength has returned to the patient, he must be warned to never again have confidence in his power of resistance with alcohol in his blood. Let him that thinketh he standeth then take heed lest he fall again. The cure of the drink habit is not always perpetual; it is not everlasting without the aid of the patient himself. Though to some the appetite never comes back, to others it is not safe to trust it with temptation. So that the safe plan, since no inebriate fully knows the full extent of his own inherent organic instability, is to "touch not, taste not, handle not," ever after. His treatment leaves him strong enough say "No," and "Get thee behind me, Satan," to his tempter. It does not alway leave him so strong that he can take the tempter to his bosom. He cannot always try a tussle with the tempter and not be thrown.

### The Drainage of Pyosalpinx Through the Uterus.

In a paper read before the American Gynecological Society, Dr. Murray joins with Dr. Polk and others in claiming that pyosalpinx can be cured without resort to the removal of the offending organ. The patient must be anasthetized, the uterus dilated, and then thoroughly curetted. He formulates the following conclusions:

1. That many cases of pyosalpinx are curable without mutilating operations if the endometritis be treated by curettage and drainage with strict antiseptic percautions.

2. That uterine curettage and drainage should be practiced in every case before operation unless the tubes are very distended and thin, to cure the endometritis which may be and often is cause of trouble and of the lack of relief after celiotomy and removal of the organs have been performed.

3. That even after pyosalpinx frequently the tubes and ovaries are not useless organs, the proof being that pregnancy occurs and the puerperium is normal.

4. That only after proper treatment, the tubes, ovaries and uterus still remaining bound down by adhesions and continuing a menance to life and health, should the radical operation be done.—*Pacif. Med. Jour.*

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*Meeting December 5th, 1893.*

Dr. L. S. McMurtry read a paper on

HYSTERECTOMY.

(See page 159)

VIOLENT CASE OF LA GRIPPE.

DR. T. P. SATTERWHITE: I would like to ask the members of the society if they have seen any violent cases of the fashionable disease "La Grippe." The reason I ask is that a week ago last Sunday I was called to see a lady who is about six months advanced in pregnancy. She was perfectly well the day before; in the morning she felt a little indisposed and about two o'clock she was taken with violent coughing and constriction through the chest. I saw her about four o'clock in the afternoon, and thought she was a little cyanotic. Her respiration was about fifty; pulse 130; there was no fever, but incessant coughing. I gave her a hypodermic injection of morphine and wrote a prescription for some simple remedy and left. About nine o'clock Sunday night I was summoned, and found her decidedly cyanotic; pulse 140, but no fever. I should have stated that on my first visit, in an examination of the chest I detected some crepitation, but as there was no fever of course I excluded pneumonia, and thought possibly it was pleurisy. I asked her if she would allow me to bleed her as I thought it would give immediate relief. She consented to the procedure, and I drew from the arm probably about a pint of blood which was followed by immediate relief of all oppression in breathing, and she expressed herself as feeling very comfortable. I did not draw as much blood as I wanted to, from the fact that she said she began to feel a little sick, the current had about stopped and I did not want her to faint, consequently I put my finger over the blood vessel and stopped the flow. She had after that coryza; at no time was there any elevation of temperature, but all symptoms for some days afterward of influenza, and I thought probably it was one of the manifestations of grippe.

DISCUSSION

DR. C. SKINNER: About a year ago Dr. Bailey asked me to see a woman with him. He had just delivered this woman at full term, of a perfectly healthy baby, and the patient had been well up to the time of beginning of the labor. She had a normal, easy and quick labor, but immediately upon the termination of the labor, even before the placenta was removed from the vagina, she developed the identical chain of symptoms detailed by Dr. Satterwhite: extreme difficulty in breathing, fullness of the chest, incessant coughing, etc. Her mouth would fill with mucus as fast as she could throw it off. I saw her just at this time, and we remained there all through the night. Under the administration of whisky, occasionally with ammonium, the symptoms gradually subsided. She was not a plethoric woman at all. By morning she was feeling very comfortable. There was no expectoration of blood, but there was an excessive accumulation of mucus that interfered with the respiration. Her recovery was complete.

SUCCESSFUL CASE OF VAGINAL HYSTERECTOMY.

DR. W. H. WATHEN: A few weeks ago I reported to this society, three successful cases of vaginal hysterectomy. To-night I will report another recently performed and which will make an uninterrupted recovery. In my work in vaginal hysterectomy for malignant disease I have lost but one case; that was three years ago, and resulted because of ignorance of the necessity of thoroughly curetting the necrosed tissue away before attempting the hysterectomy. Since then I have had no trouble, and my patients recover without sepsis.

The patient is an elegant lady of nervous temperament, and has never been a strong woman. I treated her several years ago for some uterine or pelvic trouble. On her recent return from Europe, her family physician called me in consultation to see her. I diagnosticated cancer of the cervix, which had existed to an extent to attract her attention for six months. The cancerous mass in the cervix which was larger than a hen's egg, was thoroughly curetted and left for two weeks before an hysterectomy was done. By this time the tissues had contracted so that the ulcerated surface was no larger than a nickel, simplifying the operation and doing away with the danger of sepsis from the necrosed tissue. The cervix was again curetted immediately before the hysterectomy was performed. The uterus was easily removed and the broad ligaments were clamped; no sutures were used. It required but two clamps to control bleeding and the patient did not lose over one-half ounce of blood. In my previous hysterectomies I was compelled to use more than two clamps. Sometimes ligatures were also applied. She had no shock, vomited but little, and the pulse did not go above 65 for nine days, and there was no elevation of temperature. But on the tenth day, from imprudence in eating, she had indigestion and the pulse was 100 and the temperature 101° F. for six hours; she

has since continued in a normal condition. I wish to emphasize the fact that as a result of the operation, the temperature was not elevated nor did the pulse go above 65.

Vaginal hysterectomy is primarily one of the most successful of all capital operations. I do not think it important whether we use clamps or sutures, and the results will be as good with one as with the other.

I was recently interested in reading the report of a series of hysterectomies, for some reflex troubles, by a physician in another city whom we do not recognize as "regular." I was interested because he claims to remove the uterus and control hemorrhage without the use of clamps or ligatures. While this may sometimes be possible, to get information from another source I wrote to a distinguished laparotomist in Chicago and inquired if it were true that this kind of work had been done there. He replied that he had never seen the work of this man, but that another distinguished gynæcologist had, and says that clamps or ligatures are used. If the uterus could be removed without the use of ligatures or clamps, it would be a beautiful operation. In the cases reported by this gentleman, hysterectomy was not indicated because they could be treated and cured by other less heroic means; and the uterus, ovaries and tubes should not be removed unless no other treatment will cure the patient.

DISCUSSION.

DR. J. M. MATHEWS: There is one point in the remarks made by Dr. Wathen which should receive more than passing notice; that is in reference to the gentleman who claims to do a hysterectomy without clamp or sutures. Two months ago I was in the office of a distinguished surgeon of Chicago, and he told me that a few weeks previously, two ladies had come into his office to see a neurologist (the two gentleman had their offices together) and when he (the neurologist) stepped up into the reception room, one of the ladies addressed him about as follows: "Doctor, I have come here to have you apply some electricity and before I engage you to do so, I should tell you that I have just had my womb removed, and my friend here also has had her wombed removed." This doctor was a gentleman of distinction and learning, and said: "Madam, you must be mistaken, you have not had your womb removed." In reply to this the lady remarked, "Well, Doctor, I suppose you can tell by making an examination; investigate for yourself and see if it is true." He told me that the Doctor made an examination and found of course that the womb had been removed, and upon questioning the two ladies he ascertained that it was not especially for any womb disease that they had the operation done, but for some reflex neurosis; that they had also, undergone the so-called new American operation, which is the resection of two inches of the lower rectum; that they had also had their urethras dilated and before the womb had been removed, the cervix had been dilated. This gentleman in commenting upon it to me remarked that it was no new thing; that the gentleman who removed the wombs of these two ladies had reported thirty cases at that time, where the womb had been removed for reflex disturbance, etc., etc.

Now, I say that it should receive more than a passing notice from the gynæcologists here in Louisville, for the reason that if this thing is true, it should receive the condemnation of all right-thinking men in the profession of America. That women should submit to having their wombs removed where there is no ocassion for it is an outrage, and certainly if this man's claim is not a true one, if he did remove the wombs in this manner, then that portion of his work should be exposed; and I surely think it deserves recognition enough from the gynæcolgists of this country to look into the work and find out if this thing is actually going on, if for nothing else than condemn it.

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Dr. S. G. Dabney (visiting) read a paper on

ELECTRO-PUNCTURE FOR REDUCTION OF TONSILLAR HYPERTROPHY WITH CASES.

(See page 162)

DISCUSSION.

DR. WM. CHEATHAM: I used the electro-puncture sometime ago more than I use it now. The cases Dr. Dabney has spoken of are those in which we use the electro-puncture mostly. I think a great many of these cases may be relieved by punching out the tonsils. I have had made for this purpose a punch, and by pressure on the outside of the neck shoving the tonsil well in, I have been able to get the tonsil out by means of the punch. One serious objection to the use of electro-cautery is the pain that it produces. I object to the use of cocaine because we are much more liable to have secondary hemorrhage. I have found that usually tonsils can be removed either with a small tonsillitome (Mathieus) or with the punch.

As to hemorrhage from tonsils: I do not think it is so dangerous as a great many operators would have us to believe. Hemorrhage of a serious nature occurs so seldom in this situation that I do not think it need be feared. I have never seen a case of serious hemorrhage following tonsillotomy. I remember in one instance after removal of the tonsils from a child, there was a moderate hemorrhage which was easily controlled with tanno-gallic acid. With the instrument which I show you here, pressure can be applied, so I do not fear hemorrhage at all. It always seemed to me that there was always greater danger of sepsis following the use of the galvano-puncture than the knife on ac-

count of the slough that follows. Again there is a much more dense area of cicatrical tissue left after operations with the galvano-puncture than follows the use of the knife.

I have one of the instruments exhibited by Dr. Dabney in my office, and have used it occasionally in cases in which its use was indicated, and while it is the most perfect instrument of the kind yet invented, there are several objectionable features. The instrument for controlling the current is the best that I have ever seen, and the size of the instrument as a whole is in its favor as it can be conveniently carrried from place to place.

DR. J. M. RAY: The question of hypertrophy of the tonsil is an extensive one. The subject to which Dr. Dabney particularly referred is one that has interested me to a very great extent. I have used the galvano-cautery; I have one of these instruments and have used it in my office for a year. I find it the most reliable and most satisfactory form of galvano-cautery that I have ever seen. It has been my practice in the treatment of hypertrophied tonsil in the adult to use something else than excision. Wherever it is possible to effect removal of the tonsil by the galvano-cautery instrument of Wright, I think it will be found to work very nicely. I have employed it a number of times with satisfaction, and without any hemorrhage. I have also used the irido-platinum wire snare with success. I have frequently found fibrous tonsils not particularly enlarged, containing crypts filled with concretions giving rise to foul breath, and frequently the patient complains of attacks of dyspepsia and other reflex symptoms from the presence of these concretions in the tonsillar crypts. I very frequently have a great deal of satisfaction from the application of chloride of zinc in saturated solution after slitting up the opening into the crypt. I believe in this way marked atrophy of the tonsil may be accomplished. I frequently see tonsils buried behind the pillar of the fauces, containing a small quantity of cheesy matter, which is very foul and giving rise to very serious reflex troubles.

The last time the question of removal of the tonsils was discussed I stated that I had recently had some disagreeable results from removing the tonsils in an adult. I have had two or three cases where there was considerable hemorrhage. I must say that I am somewhat timid about excising such with the guillotine. My experience has led me to have very serious misgivings in this direction. While the galvano-cautery is of great service in the treatment of hypertrophy of the tonsils, it certainly makes the throat very sore for some time. I am very careful to find the opening in the crypt of the tonsils, and make my applications so as to get as nearly the bottom of the crypt as possible.

I never hesitate about removing the tonsil in a child under fifteen years of age, by the guillotine, passing the instrument well down, and cutting out all I possibly can. But in the adult I always feel somewhat uneasy about the after result.

As to the best method of controlling hemorrhage in this situation; A great many instruments have been suggested for pressure on the tonsil to stop the bleeding. I have found, however, that in a majority of these cases the throat is very sensitive, and any instrument passed into the throat is very hard to keep in position; even if the patient would tolerate it the contraction of the muscles of the pharynx would push it out of place. All instruments in my hands for this purpose have proven rather unsatisfactory. The best thing I have found for controlling hemorrhage in this locality has been my thumb. If the bleeding gets to a point where I am unable to stop it by local applications, such as tanno-gallic acid solution, or the packing of powdered tannic acid into the bleeding surfaces, I pass my thumb well in between the pillars of the fauces, and by keeping up the pressure for a few minutes, allowing the blood to clot in the vessels, I have always been able to stop the hemorrhage in this way.

DR. WM. CHEATHAM: I believe there is considerable danger of secondary hemorrhage after use of the galvano-cautery puncture, knife or snare; my objection to the snare especially, is the danger of secondary hemorrhage. If there is going to be any hemorrhage, I would rather use the guillotine and have the bleeding occur primarily. After use of the galvano-cautery a lough takes place, and there is danger of secondary hemorrhage six, eight, ten or many hours after the operation. We have no such danger to contend with following the knife.

DR. S. G. DABNEY: The discussion has taken a turn rather wider than the remarks I made called for. In deep-seated septic tonsils we must use something else than the knife, we cannot reach them with the tonsillotome, and my reason for showing the galvano-cautery was to demonstrate its use in this class of cases. Many of us have tried instruments more or less similar to the gouge and small guillotine shown by Dr. Cheatham. At a recent meeting of the Medico-Chirurgical Society I exhibited a small instrument made under my direction, and combining the advantages of the McKenzie and the Mathieu instruments. Still such instruments are not usually so satisfactory in these cases as the electro-cautery. One reason is that it is difficult to separate the tonsil from the pillar of the fauces with these cutting instruments.

As regards the danger of hemorrhage in removing large fibrous tonsils in the adult: I have done this operation with the guillotine

without troublesome hemorrhage with exception of one case, but like Dr. Ray I never remove a large tonsil in the adult without some uneasiness. Bosworth nearly always uses the cold wire snare in operating upon cases of this kind. As to instrumental means for controlling hemorrhage following tonsillotomy I believe the most successful is Clendennen's forceps. But in my experience this method has not only given rise to very great gagging on part of the patient, but actual vomiting has sometimes followed, so the effect would really seem to me to be to increase hemorrhage rather than arrest it. The tanno-gallic acid (6dr, tannin, 2dr. gallic acid to one oz. water) is a valuable means for arresting hemorrhage. Of course, in children the danger of hemorrhage is practically nil. So far as I am aware there has never been a serious case of hemorrhage following tonsillotomy in children. There have been a very few fatal results and quite a large number of serious and alarming ones after the same operation in adults. In the only case of serious hemorrhage I have had, already referred to, the McKenzie instrument was used on one tonsil and the Mathieu on the other. Though the tonsillitome was used the hemorrhage was secondary, coming on about six hours after operating and this is very often the case.

DR. J. M. RAY: In the variety of tonsils that Dr. Dabney has mentioned it has been my experience to find a great many of them attached to the pillar of the fauces, so that in removing them we are liable to cut the pillar of the fauces. In a number of cases I have followed the suggestion that I have noticed somewhere, of simply separating the attachment of the tonsil to the pillar of the fauces and the tonsil will then shrink.

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### ABSCESS OF THE TONSIL.

DR. WM. CHEATHAM: A gentleman recently consulted me complaining of some trouble about the throat, that it was the source of constant irritation. He is an elocutionist and takes the best possible care of his throat. I examined the tonsil; it was a little hypertrophied, and there were quite a number of lacunæ leading down into the tonsil. The tonsil projected only slightly beyond the pillar of the fauces. By making gentle pressure I remove a small quantity of very thin creamy looking pus. He told me that this condition had existed for five years.

It is the first case of abscess of the tonsil existing for such a great length of time that I have ever seen. I treated the case by slitting it down to the bottom of the abscess, washing out thoroughly and making application of chromic acid. The patient has had no trouble since.

### MALIGNANT DISEASE OF THE RECTUM—OPERATION.

DR. W. O. ROBERTS: At the last meeting of this society I reported a case of malignant disease of the rectum, and brought the patient with view of having Dr. Mathews especially examine him, but as he was not present I did not exhibit the patient. He was a Polish Jew about forty-five years of age, who had been complaining of rectal disease for quite a long time, and when I examined him I found on the posterior surface of the lower end of the rectum, an indurated ulcerated surface about the size of a silver dime, and on either side of it was a hard nodule about as large as the end of your little finger. I resected about 1½ inches of the lower end of the rectum.

There is no doubt in my mind about the trouble being malignant in character, but no microscopical examination has been made as yet, of the specimen removed. The operation consisted in first splitting thro' the back part of the sphincter muscle and then dissecting the gut, pulling it down and stitching it to skin at the verge of the anus (Whitehead's operation). The nodule was located in the sub-mucous tissues and was quite hard.

### DISCUSSION.

DR. J. M. MATHEWS: The reason I suggested that Dr. Roberts' report the manner of resecting the growth was this: I am indebted in an especial way for the technique of Kraské's operation to Dr. H. O. Walker, of Detroit. At the meeting of the Mississippi Valley Medical Association at Indianapolis a few months ago, Dr. Walker reported two cases of Kraské's operation for the removal of malignant growths of the rectum, and suggested the use of Murphy's button procuring of course a very large size for the purpose, and stitching the gut above and below. He exhibited the button, but remarked that he himself had not yet used it.

In the last issue of the *American Medical Association Journal*, Dr. H. O. Marcy, of Boston, reports a case where he acted upon Dr. Walker's suggestion with a perfect result. I was impressed at the time of Dr. Walker's report that it was a most admirable suggestion, and asked him to try it on his next case and report it, that he might be on record as making this valuable suggestion in resecting the rectum. Although the credit is due Dr. Walker, his case was only incidentally referred to by Dr. Marcy in his paper.

In the case reported by Dr. Roberts, I believe that he pursued the only course, if he was satisfied that the nodule was malignant that he was dealing with. Inasmuch as the growth did not involve a larger space than he states, I believe the operation he did was quite sufficient. But it is suggested and practiced by those doing surgery upon the

rectum, that when the growth is at all extensive, or where there is disease taking in the entire circumference of the gut, or even anteriorly and posteriorly, or anteriorly and one side, that complete excision should be made. Now we are all very well aware of the fact that it is a difficult thing to do an excision and include a malignant growth in the manner Dr. Roberts suggests. I have done the same operation that Dr. Roberts did in this case, and with considerable success. I say success in that the man was able to control the passage of feces after I resected the lower end of the gut which included the sphincter muscles.

There is one point in Dr. Robert's report that I have had occasion to mention before. I know many authorities say that it is the proper thing after a division of the rectum to bring it down and attach it to the true skin. I have attempted to do this, and in several instances thought I had succeeded, but in each case the stitches separated, and I had trouble later from the granulating surfaces, and there was free discharge of pus. I suggested a number of years ago that where a resection, say of 1½ inches of the lower rectum is made, it is best to leave the gut without stitching and allow cicatrization to take place, the surface healing by granulation, inasmuch as the cicatrization itself would act as a wonderful aid in controlling the feces, especially if the sphincter muscle is removed in doing the operation.

Latterly I see most all the men who do work in this line believe in Kraske's operation for the cure of malignant growths of the rectum, especially if it is located at any height. And there is no doubt, that by removal of a portion of the sacrum and getting in from behind, we have an opportunity to handle the rectum in a manner that we cannot possibly do unless we do this operation suggested by Kraské, which is coming into vogue and is being used by the majority of men who are operating on the rectum. Of course Kraské's operation is thoroughly understood, and it is not necessary to describe it. One great thing in its favor is that the sphincter muscles are saved.

Dr. W. O. ROBERTS: In the operation of Kraské, the disease, as Dr. Mathews says, is situated high up in the rectum, and usually there is a point below that is considered in a healthy condition. I would like to ask Dr. Mathews whether he has done or seen done the operation of Levy. That is one in which a flap is made of the soft tissues and bone above, making a transverse incision through the lower part of the sacrum, then two vertical ones, turning it down—a trap-door flap, as it were—resecting the rectum and then replacing the flap. Levy reports a number of cases in which he has done this operation with good results and it seems very plausible.

CHRONIC ANÆMIA.

DR. P. F. BARBOUR: Last summer I was called to see a patient in the absence of her regular family physician. The patient was a lady of about thirty-two; she was pale, emaciated, very weak and lying in bed. She had no abnormal temperature then, and did not have during the course of her illness. The symptoms she complained of were palpitation of the heart, which was very violent, sufficient to shake the head of the bed and waking her at night, and belching a great deal of gas from her stomach. This eructation had no connection with any particular food except that potatoes seemed to make it worse. This symptom was always present and very annoying. In addition to this she complained of some rheumatic pains in the shoulders. She had been placed upon a milk diet—I have forgotten the amount per diem. and pepsin. She did not seem to be improving upon the milk diet, in fact she was becoming weaker all the time when I was called to see the case. I examined her very thoroughly, found the lungs normal, heart dilated and a basic murmur with the first sound. There was no tenderness about the stomach, no tumor and no dilatation. As far as physical signs go there seemed to be nothing abnormal about it; the bowels were always constipated. She said that after each action of the bowels she would have slight prolapsus of the anus. She complained of leucorrhœa, only, however, during these attacks, from which she was then suffering. In each attack she would be in bed for about a month. She was very nervous; pupils would dilate and contract while she was talking. The slightest light striking her eyes would produce a very marked effect upon the pupil.

I concluded that the milk diet treatment was not the proper one in this case. It seemed to me there was some trouble at the bottom of all these symptoms, that they were not due to any functional disturbance of the stomach, but that chronic anæmia might be responsible for her varied ills. We know that chronic rheumatism is a most frequent cause of anæmia, and this patient had been suffering with pains in the shoulders and muscles of the legs for a number of years. With this idea in view, I changed the treatment entirely. I put her upon six meals a day, of course giving a small amount of food at a time, but the most varied and nourishing food I could get her to take. I excluded nothing from her diet practically, excepting cabbage. Everything that could be easily digested was allowed her. In addition to this she took iron and cod liver oil. In less than four days she had gotten up out of bed, and in the course of the next month she gained twenty-five pounds.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE MEDICAL CHRONICLE

of Manchester, Eng., for January contains a paper by Dr. W. Dowson on

**The Local Lesion of Scarlet Fever.**

The author contends that (1) The primary local lesion of ordinary scarlet fever is in the tonsil. (2) This disease is a local disease of these parts and associated lymphatic glands, the general symptoms being caused by the absorption of toxines produced by the microbic growth at the local lesion. (3) The incidence of the disease aud the subsequent immunity are related to the structure and life history of the tonsils.

The author has made over 500 observations and tabulates the results in the paper. He sums up as follows:—(1) tonsilitis is invariably present from the very first in scarlet fever; (2) it is the first sign apparent both to the patient and to observer; (3) it recurs in in relapses; (4) its severity is directly proportional to the severity of the other associated features of the disease; (5) this difference in severity of the throat affection and its relation to the other marks of the disease are recognized as affording a basis, to a great extent, for the clinical classification of the cases of this disease; (6) it is absent just in those cases where there is probability that the local infection takes place at an unusual situation, as in surgical and puerperal scarlet fever; (7) it leaves in the tonsil a permanent lesion, which can be observed long afterward; (8) people who have normal tonsils have not suffered from scarlet fever; (9) people who have gone through an attack of scarlet fever have not normal tonsils; (10) the immaturity of the tonsils at birth, their development in early childhood, the onset and establishment of puberty acting by way of the tonsils, and the atrophied condition of these organs after the age of thirty, control to an important extent the incidence of this disease.

He believes that although the truth of these propositions has by no means been rigidly proved, yet the weight of evidence is decidedly on their side; and that it is more philosophical to regard a lesion with such relations to the rest of the phenomena of a disease, as characterize the tonsillitis of scarlet fever, as a cause, than to make this consequent upon and merely symptomatic of a specific septicæmia or some other circumstance of the existence even of which no satisfactory evidence is to hand; that, in fine, as in diphtheria, the throat condition and cervical bubo of scarlet fever are the analogues of the chancre and inguinal bubo of syphilis, or of the intestinal ulcers and enlarged mesenteric glands of enteric fever.

Dr. Charles G. L. Skinner advocates

**The Use of Salol in Diarrhœa.**

During an epidemic of summer diarrhœa, of twenty-three cases treated with salol, only one—a child eight months old—proved fatal. In very few cases were more than three or four doses necessary, and rarely were more than one or two loose stools passed after taking the first. Ordinary catarrhal diarrhœa, due to errors of diet, diarrhœa of children, diarrhœa occuring in the course of some other disease, two or three doses seldom fail to arrest, whilst in the diarrhœa of tuberculosis it can generally be relied upon to give temporary relief. The author has had no experience with the drug in typhoid fever, but thinks it worthy of a trial in this disease and and also in cholera.

In all these varieties of diarrhœa, the good effects of salol are most probably due entirely to its direct antiseptic action on the bowel contents—destroying bacilli, controlling acid fermentation of food and the putrefaction processes. The sedative action of carbolic acid will also lessen the peristaltic movements, and so relieve pain. The dose of salol for an adult is 10 to 15 grains (best administered in a teaspoonful of gruel or barley water), which may be repeated every four or six hours; to a child a year old, 1 or 2 grains may be given. It is very rarely rejected by the stomach, and in the above doses does not produce unpleasant after effects.

It is, however, necessary to guard against the possibility of carbolic poisoning by not continuing the administration of the drug over too long a period, or giving too large or too frequent doses.

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BRITISH JOURNAL OF DERMATOLOGY FOR JANUARY, 1894.

Dr. W. Allan Jamieson writes of

**Acne:**

Acne is, when fully developed, a pustular inflammation, having its seat about a sebaceous gland, either on the face, or the anterior and posterior aspects of the thorax. He does not include similar eruptions elsewhere. The small pustular syphilide is widely diffused, and accompanied by constitutional symptoms.

The cause of acne seems to be disturbed circulation in the skin, coincident generally with debility, and imperfect sexual development, or indigestion, and the abuse of tea or alcohol.

The treatment is general hygienic, usually the use of iron with salines, touching the individual pustules with one part of ichthyol to four of water, or liquid carbolic acid, instantly followed by flexible collodion

Expression of comedones, followed by hot water bathing, and the use at night of a lotion composed of sulphur, glycerine, spirits of camphor and lime water.

℞ Potassæ Sulphuratæ.....
Zinci Sulphatis.....(ää ℥j).
Glycerini.....(℥j).
Sp. Vini Rectificati.....(℥ij).
Aquæ q. s. ad.....(℥iv).

In the morning bathe in tepid water and dust with the following:

℞ Acidi Borici.....
Zinci oxidi..... (āā 5j)
Talci..... (5j)
Boli Armeniæ q. s.....

Occasionally a small subcutaneous abscess requires to be opened with a fine knife.

Dr. Louis Wickham, epitomising Prof. Fournier, says: The term

**Syphilis Maligna Precox**

is applied to tertiary lesions, usually of the skin or nervous system, occuring during the first year after infection.

The skin lesions are large numbers of disseminated, rapidly extending, deeply ulcerating sores, so characteristic as often to permit of an instantaneous diagnosis. Phagedænic tertiary lesions always are early. This early form is always rebellious to treatment, the lightning variety killing in a few weeks.

*Treatment:* Boracic acid baths to get rid of scales, pus, etc. Mercurial plaster on the superficial ulcers changed night and morning.

No potassium iodide is used, and, when there is much anæmia mercury is postponed, and a mixture of extract of cinchonæ, grammes 3 to 6; syrup of bitter orange peel, grammes 60 is used. Also iodo-tannic syrup, made as follows: Iodine, 2 grammes; soluble extract of rhatany, 8 grammes; syrup 1000 grammes; a teaspoonful night and morning. Milk is to be used freely, the urine to be watched, and when the improvement becomes marked, fresh pills of the proto-iodide of mercury with extract of opium are used.

The successful treatment of a case of angiokeratoma by puncture of each lesion with electro cautery needle is mentioned.

Success is also claimed for the treatment of obstinate eczema by poulticing, following this by a preparation of soft soap for twenty-four hours, or green soap, oil of cade and sulphur, equal parts, or salicylic or pyrogallic acid ointment to set up an irritation, which is then calmed down, to be excited again, and the process repeated as often as seems necessary. Sometimes mercurial plaster is applied over, but never beyond the inflamed area, to cause the irritation.

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THE NEW YORK JOURNAL OF GYNÆCOLOGY AND OBSTETRICS

for January, contains an article on

**Vaginal Hysterectomy and its Limitations,**

by Alexander J. C. Skene.

The author, while favoring hysterectomy as a treatment af cancer of the uterus, does not believe that human life has been prolonged sufficiently to make one very enthusiastic over this mode of treatment; notwithstanding the favorable mortality of recent surgery. He recognizes a vast difference in the general condition of patients suffering from this disease. It is his belief that certain organizations have a deficient circulatory apparatus and are prone to degenerations of all kinds. In this class are included those in whom the pulmonary artery is undersized, a condition which has been found post-mortem in all cases observed who have died early in life from malignant disease of any part of the body. Further study may throw light on this diathetic condition. As between vaginal hysterectomy and other operations in the treatment of malignant disease. he thinks that hysterectomy is the most reliable treatment in certain conditions, but should only be classed with other recognized modes of treatment and not entirely replace them. The operation is indicated, in his opinion, when the disease occurs near or after the menopause; when it begins in the corporeal endometrium and a positive diagnoiss has been made; when the disease has not invaded the vagina or Fallopian tubes to any marked extent, and before necrosis has begun in any part of the normal tissue.

The starting point of malignant disease has an important bearing in the choice of operation. When it begins in the cavity of the body, vaginal hysterectomy is the only operation to consider. Vaginal hysterectomy is not contraindicated, but is less liable to be followed by a favorable result when necrosis has begun in the diseased tissues.

High amputation, curetting and cautery are safer in perhaps a majority of cases of malignant disease and will give as complete and perhaps as prolonged relief as vaginal hysterectomy.

Summing up his views on this subject he states that in certain cases of cancer of the uterus vaginal hysterectomy is by far the best treatment and gives the most perfect relief and longer life than any other method. In other cases it is a more dangerous operation by far and does not prolonged life in a greater degree.

Following is a report of three cases.

Dr. Hiram N. Vineberg contributes an article on

**Anterior Vagino Fixation of the Uterus for Backward Displacements; a new Operation.**

He points out that the idea originated with Sanger in 1888. He gives in detail the technique of the operation with a report of four cases and concludes as follows:

1. Vagino-fixation is a perfectly safe operation and not difficult to perform.

2. It fixes the uterus in a more normal position than the other operations in vogue for backward displacements.

3. If unsuccessful it is not followed by any untoward sequelæ.

5. It finds its indication (a) in uncomplicated mobile retroversions with symptoms, when a pessary for some reason or another can not be worn; (b) in backward displacements with moderate adhesions which can be easily broken up under narcosis; (c) in the same class of cases with more firm adhesions, but which admit of being distended by an prior course of pelvic massage; (d) in prolapse of the uterus of the first or second degree with corresponding prolapsus of the vaginal walls; (e) in retro displacements of the uterus complicated with diseased annexa not calling for a radical operation—meaning salpingo-oophoritis of a moderate degree.

It is contra-indicated (a) in complete prolapsus, (b) in congenital retro-displacements, with very dense adhesions, (c) in those cases

of retroflexion in which the fundus is very much enlarged, and the isthmus atrophied to such an extent, as to give the so-called Hegar's Sign in the non gravid uterus, (d) in those cases of retro-displacements complicated with diseased annexæ, to such a degree as to call for a total removal.

Dr. John B. Harris, reports fifty operations on the uterine cervix for laceration, and regards the operation as one of the most serviceable and satisfactory within the scope of the gynæcologist. For suture material he has used satisfactorily, wire, silkworm gut and catgut, but prefers silkworm gut. The treatment of the patient prior and subsequent to the operation as well as the mode of procedure in the operation is detailed.

Dr. H. G. Wetherill under the title of

**"Hysterectomy for Uterine Fibro-Myoma."**

makes some general observations on the necessity for removal of this class of tumors, and the great advance within five years in the surgery involved, and compares the results obtained by the three methods of operation: (a) method of extra peritoneal treatment of the stump (b) method of enucleation, (c) Baer's method. He concludes that methods (b) and (c) aretechnically perfect and attended with a minimum of shock, hemorrhage, pain and unpleasant sequllæ.

Dr. Arthur Bird in a brief article under the heading:

**"Alexander's Operation."**

enumerates some of the disadvantages of this procedure, as follows:

1. Shortening the round ligament does not relieve the condition causing the displacement. It is directed to the relief of a symptom and not to the cause.

2. It does not restore the uterus to its normal position or place in the pelvis. The obstructed circulation in the pelvis is not relieved, but on the contrary is often increased.

3. The shortened legaments again become stretched, or give away from their attachments allowing the uterus to fall back into its former retroverted position.

4. Great liability to hernia follows the operation.

# PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

## THERAPEUTICS.

### Treatment of Wound of the Common Femoral Vein.

Niebergall (*Deutsche Zeitschr. f. Chir.*, Band 37, Hefte 3 and 6) objects to the practice of tying both the common femoral artery and its accompanying vein in cases of complete or partial division of the latter vessel. By applying ligatures to both artery and vein the blood pressure necessary for dilating the collateral veins is prevented. The cyanosis and œdema observed in the lower limb after ligature of the veins alone are the results of this blood pressure, and usually disappear in the course of a few hours, after the collateral venous circulation has become freely established. Gangrene did not occur in any one of 25 collected cases of ligature of the common femoral vein for wound of this vessel caused in the removal of large growths from the upper part of the thigh. Of 10 cases of ligature of this vein for non-surgical wound, gangrene was observed in only one, which occured long before the antiseptic era. On the other hand, the results of simultaneous ligature of both artery and vein have hitherto been very unfavorable, gangrene having resulted in 62.5 per cent. of the cases in which one or both vessels had been wounded during the removal of a tumor, and in 50 per cent. of the cases in which either the vein alone or both artery and vein had been opened by non-surgical injury. The prognosis in these latter instances, though very unfavorable, does not absolutely indicate primary amputation. The limb should not be removed until after the appearance of gangrene. The following are regarded as the causes of the frequent occurrence of gangrene from ligature of both artery and vein: local anæmia of the peripheral parts of the limb which are thus rendered liable to become necrosed; infiltration of blood in the soft parts and vascular sheaths, which hinders the flow of blood along the small arteries and its return by the collateral veins; as a consequence of the presence of blood clot in the tissues there is a tendency to the absorption of fibrin ferment through the walls of the veins, and to coagulation of the blood contained within these vessels. Compression of the vein, partially divided by antiseptic plugging is not likely to be of service except in cases of small external wound, and therefore is contraindicated when the vessel has been wounded during the removal of a large tumor. Lateral ligature or sutures of the injured vein is indicated in cases of small and longitudinal wounds through its wall. In instances of total or almost total division of the vein circular or complete ligature is always necessary. In cases in which the vein is so involved in a maliguant growth that its walls are infiltrated with morbid structures the affected portion of the vessel should be excised after the application of two or more ligatures.

### Pathology of Scarlet Fever.

Berge (*Union Med.*, December 30th, 1893) considers scarlet fever a local infection due to the streptococcus. These organisms are cultivated in the crypts of the tonsils, and there secrete a toxin, the diffusion of which throughout the organism produces the

cutaneous and mucous eruptions. Puerperal and traumatic scarlet fever results from local infection of the uterine surface, or various other mucous or cutaneous surfaces, by the streptococcus. These conclusions were based on the following facts: The scarlet fever eruption follows the affection of the tonsils; the extisence of scarlet fever with eruption in which the tonsillitis and its specific complications are the only affections; the constancy of the streptococcus in the tonsillitis of scarlet fever; the streptococcal nature of the complications of scarlet fever; the relation of scarlet fever to puerperal infection; and lastly, the ease with which the erythema-producing properties of the streptococcus can be demonstrated.

## MEDICINE.

### Transitory Aphasia in Pneumonia.

Chantemesse (*Bull. et. Mem. de la Soc. Med.*, December 22d, 1893) has observed more or less persistent aphasic phenomena in pneumonia, as in many infectious or toxic diseases. Some are due to structural lesions easily detectable—meningitis, softening, etc., while others cannot be ascribed to any such structural defects of the nerve centres. The latter class have a distinct clinical physiognomy, and usually occur at the end of the second or third day of the pneumonia. The aphasia is sudden in onset, but is often preceded by certain abnormal sensations in the head. Consciousness may not be lost, and the intellect may not be completely blunted; but at other times the attack is a regular apoplectiform one. The aphasia is identical in character with that which results from lesions of the third frontal convolution, and in the course of a few hours intelligence is sufficiently restored for the patient to indicate by gestures what he wishes to say. The lower part of the right side of the face is always paralysed, and the tongue deviates to the right; the right hemiplegia may be complete, but more often the paralysis is limited to the face, tongue, and the superior extremity. Sensibility and the tendon reflexes are usually little altered, but vasomotor phenomena, consisting in redness, œdema, and often elevation of the temperature of the paralysed limbs, may be present. The paralatic accidents do not appear to modify the course of the pneumonia, nor has their disappearance any prognostic value as regards the termination of the pneumonia. The duration of aphasia is short, sometimes four or five days or more. Sometimes twenty-four hours after the onset of complete aphasia speech is entirely recovered; the facial paralysis usually disappears with the aphasia, but complete hemiplegia, which is rare, is more persistent, and may be of several weeks' duration. Reasons for not considering the attacks hysterical are given, and they are contrasted with attacks of hysterical aphasia. In addition to other evidence against the structural nature of the lesion, a case is cited in which Berger found no changes in the brain of a patient with pneumonia who died five days after the onset of aphasia. Two hypotheses considered as possibly accounting for the attacks; one is that they are due to the direct action of toxic microbes on the nerve centres, and the other is that contraction of the Sylvian artery and its branches is induced, with consequent disturbance of the circulation in connection with the nerve centres which this artery supplies. The author inclines to the latter views as being the probable explanation of the phenomena.

### Idiopathic Hemorrhage of Septic Origin in Infants.

E. v. Dungern (*Centralbl. f. Bakt.*, October 28th, 1893) describes a case of this nature. He alludes to previous work upon this subject, which goes to show that idiopathic hemorrhage occurring in newborn children is frequently to be traced to bacterial influence. The organisms hitherto found are streptococcus pyogenes, B. pyocyaneus, and certain undescribed bacilli. The extravasation of blood has been explained on a theory of embolism. In the case now described, v. Dungern isolated an organism which produced hemorrhagic septicæmia in certain animals. The case was that of an infant without any family history of a nature to throw light upon the condition manifested. It died six days after birth, having exhibited the following symptoms—great emaciation, slight rise of temperature, scattered petechiæ, hemorrhage from one ear, and from the mouth, nose, and bowel. At the necropsy blood extravasations were found in accordance with the clinical symptoms, and there was also thrombosis of the umbilical arteries, the connective tissue about which was infiltrated with effused blood. In clot taken from these vessels there was found a bacillus with the following characteristics—length 1 to 2 m., breadth one-half the length; a well-marked capsule present; no movement seen; unstained by Gram; no spore formation; growth at the room temperature, in presence of oxygen, upon the ordinay media, with gas formation. The bacilli often occur in twos. They are pathogenic for mice, guinea-pigs, and rabbits. In animals of the last two classes, in which death followed rapidly upon subcutaneous injection of a broth culture of the bacillus, blood extravasations, some containing the organisms, were found scattered extensively about the various organs. Von Dungern is unable to decide whether the capsule bacillus now described is a viruleut form of the pneumobocillus (Friedlander) or a distinct organism. He regards it as the cause of the disease under consideration. The proximate cause of the blood extravasation is probably the damage done to the walls of the blood vessels by the toxic products of the bacillus.

### The Influence of Intra-Nasal Conditions Upon External Affections of the Nose.

Little literature is to be found on this subject. Crying produces a hyperæmia of the

Schneiderian membrane, also external redness and swelling of the nose. The same is true of hay fever and influenza. Strumous subjects with enlarged turbinated and thickened septa have thick ended noses. Conversely the narrow pinched nose of atrophic conditions is well marked. There are, however, many conditions in which the external or internal condition of the nose depend on a common cause, as acne and rosacea. The deductions are as follows:

1. Intrinsic nasal disorders are capable of exerting a decided influence upon certain conditions of that organ.

2. That in a few instances, at least, the external conditions depend largely, if not entirely, upon intrinsic influences.

3. That while in some cases the extrinsic condition may depend largely upon general causes not immediately associated with intrinsic exciting conditions, nevertheless the extraordinary activity of the nasal circulation, together with the existence of special nasal irritation may exert a decided influence upon the extrinsic condition of the nose.

4. In the latter case, while general treatment of the extrinsic condition must be mainly relied upon, relief of the internal condition by means of local treatment will naturally assist in affecting a cure.—D. Bryan Delavan in *American Medico-Surgical Bulletin.*

### Chloroform in Chronic Gastric Ulcer.

The treatment of chronic gastric ulcer has undergone no essential change during the last twenty years. It is the same as practiced and theoretically established by Von Ziemssen. However it is a well known fact that the customary treatment, owing to its long duration, is often impracticable. The author reverts to a method he has practiced a number of years. He endeavors to arrest by means of some antiseptic fluid the process of fermentation and decomposition in the stomach, avoiding all injurious action upon the ulcer, but at the same time aiming at the harmless stimulation of the torpid wound-surface. He employs chloroform water with Bismuth subnitrate in the following formulæ.

| | |
|---|---|
| Chloroform | 1 part |
| Water | 150 parts |
| Bismith Subnitrate | 1 part |

One-half teaspoonful every hour.

He declares that he has never observed any anodyne effect of the chloroform thus administered. The refreshing taste of the mixture most efficiently combats nausea and the severe thirst after hemorrhage; and any inclination toward further hemorrhage is overcome by the styptic properties of chloroform. The effect of this treatment is said to be striking, both in fresh ulcers and those of long standing. The sallow appearance of the patient disappears in a few days after treatment with chloroform and the malaise abates. The antiseptic action of the chloroform arrests the formation of septic substance during digestion; and its stimulant effect on the mucous membrane and ulcerated surface occasion a fresh formation of granulations resisting the absorption of septic substance, and brings about a cure within a few days, it is stated. The patients always experience a burning sensation at a certain spot over the stomach,—undoubtedly over the site of the ulcer, after taking the medicine, which no longer occurs however after 8-10 days.

In the author's cases, nutrition consisted at first of milk, or black tea with milk in equal proportions and toasted bread; at the end of the second week, of bouillon to which an egg was added later on; from the third week on, once or twice a day an additional egg, from the fourth week on easily digestible meat. A good red wine was allowed after the first week; constipation was treated with mild purgatives.—*Dr. Stepp. in Ther Monatsh.*

## SURGERY.

### Dawbarn (R. H. M.) on the Treatment of Sprains.

I divide sprains into three degrees, viz.: a mild sprain, a severe sprain, and a sprain of a still severer character. The treatment I would advise for a mild sprain would be the use of hot water and massage by means of vaseline. For a more severe degree of sprain I would apply the same treatment, plus Martin's rubber bandage, and urge the patient to walk about; and for the third degree of sprain I would use hot water as before, and a plaster-of-Paris splint, which would not be applied until twenty-four hours after the injury.—*Internat. Jour. of Surg.*

## OBSTETRICS.

### Cyst or "Hydrocele" of Nuck's Canal.

Fortin (*Rep. Univ. d'Obstet, et de Gynec.*, November, 1893) described a case of labial cyst not arising from the vulvo-vaginal glands. The patient was a married woman, aged twenty-six, strong and accustomed to bicycle riding. In April, 1892, she noticed a swelling in the right labium majus, not painful but inconvenient. It lay in the anterior part of the labium, and projected inwards. In diameter it measured four-fifths of an inch. It was irreducible, and, on account of its connections, it could not be entirely grasped between the finger and thumb. In April, 1892, shortly after its discovery, the cryst was punctured, glairy fluid escaped, and a 2½ per cent. solution of chloride of zinc was injected; no inflammation followed. In October, 1892, the cyst was tapped again, and creasote glycerine was injected. In January, 1893, it was dissected out. The detachment of its wall proved difficult. It extended above into the inguinal canal, ending in a cork-like pedicle. When removed it measured over two inches in length. No ligatures were required; there was much general oozing. Salol and absorbent gauze were used for dressing without drainage.

### A New Indication for Supravaginal Hysterectomy.

Under this title, Lauro (*Rif. Med.*, October 23rd and 24th, 1893), describes a case occurring in his own practice, and takes the opportunity of reviewing the indications for operative interference in displacements of the uterus. His conclusions are as follows: (1) In sexually active women, affected with retrodeviation of the uterus without any adhesions to the walls of the pelvis posteriorly, the intense sufferings in such cases can often be relieved by Dr. Alexander's operation, the severer operation of hysterectomy being thus unnecessary. (2) During reproductive life, in a woman afflicted with retroflexion or retroversion complicated by adhesions, the organ should be freed from its adhesions, and the round ligaments shortened intraperitoneally. This gives better results than ventrofixation of the organ. (3) In case of failure of these measures, recourse should be had to hysteropexy, by which means the organ can be more solidly fixed, without in general interfering with normal involution in future gestations. (4) Supposing laparotomy to have failed to prevent the return of the retrodeviation, and life to be in consequence a burden to the patient, one is then justified in suggesting exterpation of the reproductive organs. But this should never be done without a previous consultation. (5) In such cases the operation to be preferred is an abdominal hysterectomy so that adhesions contracted as a result perhaps of former operations, with the abdominal organs may be better dealt with. Such adhesions are often missed even by the most careful examiner before the operation. (6) If the menopause is past, there need be less hesitation in proceeding to hysterectomy. (7) The two operations, abdominal and vaginal hysterectomy, seem to differ but little on the score of danger to the patient, as in both cases the peritoneal sac has to be opened.

## ARMY AND NAVY.

U. S. MARINE HOSPITAL SERVICE FOR THE FIVE WEEKS ENDED JANUARY 20, 1894.

Bailhache, P. H., Surgeon; detailed by the President as Delegate to International Sanitary Conference Paris, France, January 15, 1894.

Sawtelle, H. W., Surgeon; detailed as Chairman Board for physicial examination of officer Revenue Marine Service, January, 19, 1894.

Austen, H. W., Surgeon; to represent the service at International Medical Congress, Rome, Italy, December 16, 1893.

Stoner, G. W., Surgeon; granted leave of absence for seven days, December 22, 1893.

Irwin Fairfax, Surgeon; to proceed to St. Petersburg, Russia, for duty December 28, 1893. To proceed to Paris, France, for temporary duty, January 16, 1894.

Carter, H. W., Surgeon; to report at Bureau for temporary duty, December 17, 1893.

Banks, C. E., P. A. Surgeon; detailed as Recorder Board for physicial examination of officer Revenue Marine Service, January 19, 1894.

Peckham, C. T., P. A. Surgeon; granted leave of absence for seven days, January 6, 1894. Granted leave of absence for six days, January 11, 1894.

Glennan, A. A., P. A. Surgeon; granted leave of absence for five days, December 20, 1893.

Brooks, S. D., P. A. Surgeon; to proceed to Sandusky, Ohio, as Inspector, January 17, 1894.

White, J. H., P. S. Surgeon; granted leave of absence for thirteen days, from December 18, 1893.

Caningron, P. M., P. A., Surgeon; granted leave of absence for thirteen days, from December 18, 1893.

Williams, L. L., P. A. Surgeon; granted leave of absence for fourteen days, January 17, 1894.

Bratton, W. D., P. A. Surgeon; to proceed to Wilmington, N. C., for duty, January 9, 1894.

Woodward, R. M., P. A. Surgeon; granted leave of absence for ten days, December 18, 1893. Granted leave of absence for fourteen days, January 17, 1894.

Stoner, J. B., P. A. Surgeon; to proceed to Marshfield, Oregon, as Inspector.

Gurterasly, M., P. A. Surgeon; to proceed to New Orleans, La., for duty.

Perry, J. C., P. A. Surgeon; to proceed to Norfolk, Va., for temporary duty.

Young, G. B., Ass't Surgeon; granted leave of absence for three days, January 1, 1894.

Brown, B. W., Ass't Surgeon; granted leave of absence for thirty days, December 16, 1893.

Rosenan, M. J., Ass't Surgeon; to proceed to Evansville, Ind., for temporary dury, January 13, 1894.

Gardner, C. H., Ass't Surgeon; to proceed to San Francisco Quarantine for temporary duty, December 22, 1893.

Nydegger, J. A., Ass't Surgeon; granted leave of absence for twenty-three days, December 20, 1893.

Oakley, J. H., Ass't Surgeon; granted leave of absence for twenty-five days, December 20, 1893.

Norman, Seaton, Ass't Surgeon; granted leave of absence for thirty days, January 15, 1894.

Prochazka, Emil, Ass't Surgeon; to proceed to Louisville, Ky., for duty, December 26, 1893.

## NEWS AND MISCELLANY.

The medical staff of the Methodist Episcopal Hospital has sustained a loss by the resignation of Dr. Frederick A. Packard, whose professional duties in other institutions have forced him to sever his connection with the hospital. The trustees will shortly fill the vacancy.

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## ORIGINAL ARTICLES.

### A STUDY OF THE ILL EFFECTS OF TOBACCO ON THE THROAT AND NOSE.

WILLIAM T. CATHELL, M. D., Baltimore, Md.

Early in my professional career I attended Mr. McG., a stout, middle-aged man, who died from the abuse of tobacco in smoking and chewing. The history of this terrible case was briefly as follows: He was a brass-finisher by trade, and purposely taught himself to use tobacco, under the belief that it was a prophylactic against the harmful vapors unavoidably inhaled in that occupation. From the moderate use of tobacco, he gradually drifted into the slavish habit of chewing and smoking strong plug tobacco all the time, except for a period of about four minutes taken for breakfast, five and a quarter minutes for dinner, and three and a third for supper, even sitting up in bed several times every night to chew or to whiff his favorite short-stem clay pipe.

The result was that in the course of time a warty-looking pimple or growth formed under the tongue, just posterior to the sublingual glands, which gradually enlarged, ulcerated and formed a deep sulcus at the root of the tongue, which mass gradually enlarged and became more and more malignant, until every fibre and every papilla of the tongue became diseased and enlarged to such a degree that the horrid swollen mass protruded from the mouth, with its tip and anterior third fissured and angry.

The gums became red, scurvied, and unusually separated from the teeth, many of which loosened and fell out; his breath was loaded with fetor; the lumen of the throat was enroached upon; deglutition became more and more difficult, and was finally impossible, which caused a constant dripping of saliva, resembling ptyalism. The glands of the neck, both anterior and post-cervical on both sides, next became infiltrated and enlarged, but luckily did not ulcerate; after he could not swallow, his adipose tissue was completely absorbed, his muscles all wasted, and he became fearfully emaciated, with complexion bronzed, eyes sunk, and entire countenance hideously distorted; his blood was no longer fully oxygenated, his breathing became asthmatic, and, added to all else, he could speak with only a pitiful, inarticulate sound, and finally, after protracted, unappeasable torture, death came to his relief October 11th, 1886, in his fifty-fourth year.

Microscopic examination of a section of the sublingual mass revealed the fibrous stroma and the characteristic alveolar structure and the epithelial cells of cancer.

His death certificate should have been *Tabaci felo de se,* effected by impregnating the glands of the tongue, mouth and throat, by an almost continuous application of the juice and smoke of King James' "baneful weed."

Encountering this case so soon after the death of General Grant, in July, 1885, I directed my attention early in practice, to the harm that may flow from the abuse of tobacco, and since adopting a specialty that brings me into constant contact with

the throats and noses of smokers and chewers of every age and physical condition, I have continued in this enlarged field to note its effects on these parts, and while I fain would be neither a bigot nor a partisan in any tobacco controversy, I shall in this paper attempt to sum up the results of my study and experience.

Smoking and chewing, like malaria, alcohol, coffee, tight-lacing, late hours, high-heeled French shoes and other debatable agents, do not affect all alike, and some devotees suffer so little from their use and, within certain limits, even from their abuse, as to be practically exempt from harm.

I know a man whose pipe is seldom out of his mouth except when he is eating or sleeping; and another who lights one cigar by the stump of another all day except when he is eating, who, when he is where he cannot smoke, is chewing, and habitually sleeps with a quid in his mouth, without any appreciable injury; and each of you knows robust and healthy lovers of the weed, leading active out-door lives, who can smoke and chew any and every kind of tobacco, good or bad, with apparent impunity.

But, notwithstanding such exceptions, I am fully convinced that, as a rule, the majority of all who chew constantly or smoke more than two or three cigars, or pipefulls of tobacco a day, venture on dangerous ground.

For these reasons I would divide the patrons of tobacco into three classes: 1st. Those strong and healthy persons who can use it, and, within certain limits, abuse it too, without injury; 2nd. Those who can use it in moderation, with little or no discernable injury, but suffer if they abuse it; and 3rd. Those to whom tobacco is toxic, who must suffer if they attempt to use it in any way at all.

The last two classes fall within the scope of this paper, and I have seen so many distressed conditions of the upper air-passages created or made worse by it, that I have little hesitation in attributing the existence of a considerable proportion of important throat and nasal diseases that increase, or remain obstinate, to the use of tobacco by these two classes.

We all know that nicotine and the dark-brown empyreumatic oil produced in burning, are tobacco's two most harmful ingredients, and that to this oil is due the stale, pathognomonic smell of the old pipe and of the stale stump.

Nicotine is present in about two-and-a-half-per cent. in the mildest Havana tobacco, and ranges up to about seven-and-a-half per cent in the strongest Virginia.

Notwithstanding the fact that the properties of tobacco, chemical and physical, differ in chewing and in smoking, and also with the variety—and in smoking, also with the method—yet the pathological action of tobacco on the upper air passages is somewhat the same, no matter in what form its ingredients are brought in contact with them; but as a general rule, smoking is worse, because tobacco burning either in cigar, cigarette or pipe, not only imparts everything natural to tobacco, but also adds the oil and other products of combustion, and discharges them hot into the mouth and upper air passages; and the harder the burning weed in drawn in, the more deeply these go, and thus the hot smoke, impregnated with nicotine and the oil, comes in contact with every part of the throat and nose.

The smoker takes in less of the nicotine, but more of the oil, etc.; the chewer, little or no oil, but more of the nicotine; but, chewing and smoking involve spitting or swallowing the saliva, and both impregnate all the fluids that come into contact with the mucous linings, with tobacco. On the whole, however, I have seen chewing seriously affect as many persons as smoking; but were the mass of smokers to indulge that habit as constantly as the mass of chewers do, its ill-effects on the smoker's air-passages would be much more frequently seen, and we would much oftener find the mucous membranes of the patrons of the cigar, cigarette and pipe, in a thoroughly diseased condition, because these not only keep large quantities of the harmful constituents in continuous contact with the delicate mucous linings of the parts, but also because inferior grades of strong tobacco may be, and are, used in preparing smoking tobacco; and the burning of certain salts of potassium existing in it, and the heavy heated smoke, are all added to its own irritating power.

In chewing, one escapes the empyreumatic oil produced in burning, which would always be terribly toxic to the mouth and upper air-passages were it not for the fact that while smoking there is

an abnormal secretion continually taking place from the relaxed mucous membranes which, although it makes a good vehicle for conveying the nicotine, yet prevents more than a fraction of it from being absorbed by these membranes, the balance being either expectorated or swallowed; and we all know that spitting is a waste, and swallowing these tobacco-tinctured secretions, either to prevent this waste of saliva or because there is no convenient place to spit, is very harmful to the whole economy.

Of course, the one who both smokes and chews risks all the dangers that tobacco can present.

Whether the pipe, cigar or cigarette instils most oil and nicotine, and which is safest to smoke, are also questions of importance. Short pipes, and thick dumpy cigars are most apt to induce cancers, etc., and no habitual smoker should smoke his cigar down to the very end but should throw the last third away, as analysis has shown that the arrested nicotine, nicotianin and empyreumatic oil are there, all thickly accumulated. Using pipes with long stems, and smoking all cigars and cigarettes through smokers, enables the wise to escape much of the poison and heat, and robs smoking of half its harmful powers; and the later in the day one smokes or chews, the less it injures, and the earlier in the morning the smoke or chew is taken, the more it inhibits nerve power and nutritive activity; and, further, no one should shut himself up in a small room at any time, to smoke and create around himself a cloud of nicotine, for an increased amount of poison is then condensed on the delicate mucous membrane of the whole respiratory tract, and is thence taken into the entire system.

Cigarette smoking makes a delicate person's lips and face lose their natural healthy hue quicker than any other mode of using tobacco.

Tobacco is a potent agent that certainly is capable of creating a cachexy that interferes with both growth and repair, and I find that all inflammatory affections and lesions of the throat and nose, and especially those of specific origin, are more persistent and recover more slowly in persons suffering with what I might call scurvy; and not only the specialist, but also the general practitioner, knows how difficult it is to heal lesions, whether specific or benign, in the mouths, throats, or noses of those who either chew or smoke excessively, or rub snuff; and a scratch, pimple, blister or wart, or a sore lip, mouth, tongue, or throat, may be made cancerous by keeping it bathed in tobacco juice or smoke, especially, if the person is suffering with chronic tobacco intoxication of his system. In fact, it is scarcely possible to heal a sore or ulcer in the mouth, throat, or nose of one who persists in chewing or smoking.

For the same reason, no one with decayed or broken teeth, or dental plates that rub the gums or cut the tongue or mouth, should either smoke or chew, for either of these may be the fatal starting point. I have the records of five cases of epithelial cancer of the lips and tongue, four of which occurred in great smokers. Mrs. General U. S. Grant told me, in 1886, that General Grant's fatal case of throat disease began by his abrading a spot in the pharynx with the rough skin of a peach he was eating, and I have but little doubt that constantly bathing this abraded surface with tobacco smoke and tobacco-laden saliva, while his blood was already drenched and saturated with tobacco poison, did its fatal work for him.

Further, tobacco certainly acts as a depressant to feeble people and lowers their stamina; and such persons with a cancerous diathesis, or a syphilitic taint, or a scrofulous constitution, should not use it in any form, for in all such subjects the delicate pulpy tissue of the mouth, throat and nose, is very prone to inflammatory action, and also to ulceration from smoking or chewing, and in a large proportion of cases these degenerate into or light up the affection their predisposition or constitution indicates; and, in my opinion, no one who is aware that he has inherited a diseased or weak constitution, or defective vitality, should risk reducing his stamina further, by the use of this agent; and science, in the form of physiology and chemistry teaches, and my experience confirms, that if such an one uses tobacco while growing and maturing, he will not only have a weaker body and a weaker brain, but he will also be much more liable to catarrhal ailments of the upper air-passages; and I am quite sure that all throat and nose specialists will agree that tobacco has a softening and relaxing influence on the mucous membranes of the

mouth, throat and nose, in many who attempt its use, and induces catarrhal and other affections, and that it is unwise for certain varieties of defective people to risk its bad effects.

Neither can persons suffering from any form of neurasthenia smoke or chew without injury, and yet these are the very persons who oftenest have the *furore tabaci;* some smoking innumerable cigarettes, or lighting one cigar after another until they smoke six, eight, or a dozen a day.

Smoking also creates in some persons a persistent, hacking cough, due to tenacious mucus that accumulates in the pharynx and larynx, dependent on a morbid, infiltrated condition of the tissues of the palate and throat, which often degenerates into a condition that closely resembles clergyman's sore-throat, or into diseased throat and post-nasal catarrh combined. I make an emphatic interdiction of tobacco in all such cases.

I am also convinced that in some people there exists a close sympathy between the olfactories and the nerves of the mouth, and that in some the frontal sinuses are also invaded after tobacco excesses, as gravedo and frontal headache often attest.

Besides the classes I have spoken of, whoever else finds that tobacco is injuring him should stop its use; but, unfortunately, many of those it is affecting never realize that it is doing them any harm, attributing all their ailments to other causes.

When tobacco induces a sense of tumefaction, heat and pricking in the throat, it should be let alone; and those whom it occasionally makes sick, and persons with a poor appetite, and those recovering from wasting sickness, are among the ones it injures most.

The habit of swallowing tobacco smoke and then expelling it through the nose, and also of coughing it into the lungs, are both very injurious, as they irritate and dry the mucous membrane of the pharynx, larynx and trachea, and subject them to the various tobacco affections. Blowing it through the nose is also harmful, as it is a fruitful cause of the hypertrophic thickening of its mucous membrane, so often discovered in smokers, and the sense of smell is also greatly impaired by smoke-blowing.

I would not be understood to say that tobacco induces these affections only, but it is chiefly with them that I come in contact.

With feminine smokers and chewers I have had no experience, and with snuff-pinchers and snuff-rubbers but little; but I have encountered two cases of nasal polypi in females due to the use of snuff, which is less astonishing when we remember that all tobacco dust has a notoriously irritating affinity for the Schneiderian mucous membrane.

There is in my mind a strong suspicion that the high degree of injury that follows cigarette smoking is not due solely to the tobacco they contain, but is also due in part to its union with the so-called rice-paper wrappers in combustion; and I would here emphasize that in all smoking, and in chewing, too, much depends on the quality of the tobacco.

I can usually distinguish the oral cavity of the person who carries smoking to excess by the dusky red, velvety, or hyperæmic appearance of the lining of the mouth, throat and nose, and by the throat becoming irritable and hoarse upon every effort in speaking and singing.

Tobacco cautiously used is certainly a charming pleasure in ripe manhood, and a solace in old age, and is rather beneficial than otherwise to thousands of healthy but careworn and toilworn people, and also to tens of thousands of soldiers, sailors and other idle people on whose hands time hangs heavily; and were one to ask me how to get the good out of it without risking the bad, I should advise him, among other things, to avoid smoking another's pipe, for fear of contracting disease,—the largest indurated specific sore I ever saw was on a colored man's lower lip, contracted from another's pipe; also, never to even smoke his own after it had become blackened and oil-soaked, and also never to light a stale stump, or habitually smoke a short stem-pipe.

A cigar-smoker, or a cigarette-holder, or a new or freshly burned clay pipe, in point of safety and cleanliness, is far superior to putting mouth-to-weed in smoking, and one's whole mouth and throat should be thoroughly cleansed with water after every smoke.

Neither striplings with unformed constitutions nor weakly growing youths should venture to either smoke or chew, because in youth the vital centres are all unripe and delicate, and the mucous

membranes are then marvelously hypersensitive to the effects of smoking and chewing; and if a growing boy's or an undeveloped puny youth's mucous membranes absorb either nicotine or the empyreumatic oil of tobacco, it poisons his springs of life and stunts his development mentally, morally and physically; and if he expectorates these poisons, then the loss of saliva lessens the growth and repair of his delicate and easily injured vital centres, and I am positive I have seen more than one unripe devotee stunted in body and mind, and I could at this moment name half a dozen young men and boys who are injuring their throats and noses with cigarettes, who will later in life have granular or follicular pharyngitis, somewhat akin to clergymen's sore-throat, with an annoying discharge of mucus from the posterior nares into the throat, with relaxed tickling uvula, which may hang on for years, and neither get well nor kill, but be an annoyance to himself and to every one around. I know a feeble, narrowed-shouldered young man, who is at this moment cigaretting himself to either the invalid's couch or the grave, through his delicate mucous membranes; and we, as hygienists, can do the weakly ones of the rising generation no greater service than to point out tobacco's injurious effects on their throats, upper air-passages, etc. I have observed but few youths whose sensitive mucous linings could endure tobacco's toxic influence without showing symptoms of weakness, morbidity and disease; and were I to recast our pharmacopœia I would not only call hyoscyamus hensbane, aconitum wolfsbane, and arsenic ratsbane, but would be strongly tempted to give tobacco the synonym of youthsbane.

If anyone considers this indictment overdrawn, let him stand at Broadway and Baltimore Street, or at Charles and Preston, or at any other spot where he can see a constant stream of passing men, boys and youths, and carefully scan all the immature and sickly devotees who pass with cigar, pipe, cigarette or quid in mouth, and he will soon detect written on many of their faces and figures, the unmistakable signs of tobacco cachexy, some with pale, sharp, wizened visage, round shoulders, shuffling walk and anxious, nervous, tell-tale addresses; others with complexions stained an ugly green or a dirty yellow or a dusky bronze color, as if their blood were turned to a greenish or yellowish fluid instead of the natural red.

The mouth, throat, and nose of a healthy person have a clean smooth, pale, pinkish or lilac hue. Examine these tobacco mouths, throats and noses, and you will find every part unclean and ugly; probably a mouthful of saliva, as offensive as a bar-room spit-box, that must be either expectorated or swallowed before you can begin to examine; tongue furred, teeth incrusted with a dirty, scurvy-like, greenish deposit; the buccal surface of the cheeks either in a state of active or sluggish congestion; gums, palatine arches, velum palati, pharynx, epiglottis, larynx, Schneiderian membrane, and all the other soft tissues turgid and injected, or velvety, granular, purple with hyperæmia, and streaked with mucus, instead of being a clean natural red.

You will find, however, in this flaccid throng, that all have one set of muscles that are firm and strongly developed, i. e., the muscles of the mouth and lips; made so by the local exercise of grasping the cigar, pipe or cigarette, with jaws, lips and teeth, together with the constant gymnastic motions of chewing and spitting.

Some of this tobacco throng will present cases of ozena; others, catarrh of the throat and nasal passages, buccal inflammation, epiglottitis, relaxed and tickling uvula, chronic tonsillitis, laryngitis, trachitis, hoarseness or nasal twang in talking, due to thickening within the larynx, loss or impairment of smell, rotten breath, etc., which can easily be interpreted by the experienced; and I risk nothing in asserting that five-per-cent of all constant smokers and ten-per-cent. of all constant chewers, and twenty-five per cent. of all who constantly do both, are affected with one or another of these affections, and not thirty-per cent. of immature and sickly smokers' throats and noses will be found in a perfectly normal condition.

I do not think any one can safely use tobacco in any form in boyhood or early youth, and I am sure that smoking before the eighteenth year, and chewing before the nineteenth year, cut off from many a youth half his stamina and lessen all his natural talents and attributes; and I ask you to-day, as anatomists and physiologists, to think of a frail boy, or a callow youth,

who secretes and then ejects half a pint, or a pint of tobacco tinctured saliva daily, while both he and his friends are wondering why he is below par. You know and I know that it is as unnatural and harmful to him, to keep his sensitive absorbents and lacteals bathed in tobacco-tinctured, tissue-altering saliva, either by smoking or chewing, as it would be for a fifteen month's old colt to carry heavy weights on his back; and the delicately constituted youth, who learns to "chaw" because others do, or to show his rough side, or tries to blow as big a cloud of smoke as the other fellow does, is injuring himself mentally, morally, and physically, and although he may not realize it now, yet the day is not far distant when he will know it, and know it with regret.

In conclusion, I believe the majority of those who arraign tobacco, from King James in 1641, down to the Cranks of to-day, draw their indictments entirely too heavy. Personally, I have little or no prejudice against the proper use of the weed, either in smoking or chewing. Nor would I dare to say that every votary of tobacco is injured, or is on the road to ruin. Life is short, and every one should get all the rational, harmless enjoyment out of it he can; and while I am perfectly willing to agree that some can use either mild or strong, good or bad tobacco, very freely and experience no ill effects, I am also quite positive that it is highly injurious to the upper air-passages of all youths, and also to numerous adults, and that to some of these the free use of even the mildest and best tobacco is almost akin to suicide; and I think that we as physicians should counsel all growing youths to shun it entirely, and every adult with defective stamina, or a tendency towards any organic disease, or a bias for any cachexy, or an inclination towards any affection of the throat or nose, either to let it alone forever, or to determinedly limit its use to a harmless quantity.

# COMMUNICATIONS.

## SOME EXPERIMENTS WITH SOMATOSE—A NEW FOOD PRODUCT.

E. H. BARTLEY, M. D.,* Brooklyn, N. Y.

This preparation is claimed to consist almost entirely of pure albumoses. It is prepared from meat, and is a light yellow powder without marked odor or taste. It is hydroscopic and dissolves completely in hot and cold water. The solution has a faint alkaline reaction, and part of the substance is precipitated by careful neutralization, from which we conclude that there is present a small amount of alkali-albumin. Most of the nitrogenous matter is in the form of albumoses, there being only about 5 per cent. of peptone present.

For practical purposes we may regard the new food-product as a highly nutritious preparation of meat, composed chiefly of albumoses, with a small amount of peptones. Prof. Chittenden has recently published an analysis of Somatose, giving the following as its composition:

| | |
|---|---|
| Water | 8.94 per cent. |
| Solids | 91.06 " " |
| Mineral Matters | 6.95 " " |
| Total Nitrogen | 13.90 " " |

Matters insoluble in—

| | |
|---|---|
| 80 per cent. Alcohol | 80.91 per cent. |
| Albumose | 70.07 " " |
| Gelatose and Gelatin Peptone | 8.03 " " |
| Peptone | 5.01 " " |

From this exhibition of its composition, and from the well known results of physiological and clinical tests with peptones, we might expect good results from the use of somatose.

Gerlach, Politzer, and others have shown that *fully digested* meat preparations cannot be used long without producing diarrhœa and other digestive disturbances. My own experience has shown that after a few days patients develop a disgust for such preparations and decline to take them. The stomach becomes sick, the breath offensive, and they do not thrive well without other food. The greater the propor-

* Professor of Chemistry and Toxicology in the Long Island College Hospital.

tion of peptone in these preparations the less desirable, clinically, are they. This fact has become well known in the peptonizing of milk for infants. They will not thrive on completely peptonized milk, even when they can be induced to take it, and hence, no one now thinks of thoroughly peptonizing milk for infants or invalids. The same is true of the cereals. They agree when partially digested. It is for these reasons that this new preparation has been put upon the market.

The clinical use of this food upon a variety of cases have borne out the expectation derived from its chemical composition.

The cases on which I have tried somatose, included two cases of carcinoma of the stomach, one of phthisis, one of gastric ulcer with dilatation, two of choleraic diarrhœa in infants, with marked collapse, and one of gastro-enteric catarrh (summer diarrhœa).

In all cases the food was well borne and was retained when all other food was rejected. It was noticeable that in several of the cases, where there was complete anorexia, the appetite returned after from one to three days, and then the patients were able to retain and digest other food, rendering the further use of somatose unnecessary. In no case did it produce nausea or diarrhœa. The case of phthisis pulmonalis, above mentioned, was suffering with troublesome diarrhœa, with occasional vomiting at the time of beginning the use of somatose, but there was no evidence of an aggravation of the diarrhœa. The nutritive value of the food could be plainly seen in its effect upon the digestion and blood tension.

The effect upon the heart seemed to be more permanent than that of a stimulant, and I could but regard it as the result of a true nutrient action upon the heart muscle. I would explain its effect upon the digestive organs in the same way, *i. e.*, by its furnishing nourishment to the mucous membrane of the stomach, as well as to the increased general nutrition.

From the limited experience had with it, I do not regard it as suitable for long continued use, but it is especially useful in an emergency, when the digestive organs have failed to appropriate ordinary food, and for this purpose, it has seemed to meet the indications more fully than any of the commercial peptones, or so-called peptones, tried by me. In three of the adult cases, I compared the effect of somatose with that of some of these peptones, and in each case with marked credit to this preparation.

The trial with infants was confined to two cases of typical cholera infantum, and one of summer diarrhœa, of mild type. All covered.

The first case was a second attack in the same child during the season. This attack was accompanied by convulsions, followed by alarming collapse, high internal temperature and incessant vomiting. The food was begun at about nine in the evening. A half teaspoonful was dissolved in a wine-glass of water and a teaspoonful of this mixture given every half hour during the night. The effect was very gratifying. The restlessness, the rolling of the head from side to side and throwing the arms about had ceased by morning, and natural sleep followed.

The child was then given a mixture of equal parts of milk and water with a half teaspoonful of somatose dissolved in four ounces of the mixture. This was retained and continued for two or three days, when the usual food was resumed. If any part of the treatment of this child saved its life I should give the principle credit to the food.

The second case was less severe, but the result was a rapid recovery. The third case did not return after beginning the food, and I can only say that it recovered without further attention. The one thing that impressed me in both of the above cases of choleraic diarrhœa, was the rapid restoration of the digestive functions, after such a profound disturbance. I have tried to avoid enthusiastic praise of the results obtained in these few cases. So far as they go, they seem to show that we have in somatose a valuable nutriment in cases of great exhaustion and in digestive failure. It deserves a more extended trial.

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In the Cemetery.—Tommy—"All these people haven't gone to heaven, auntie."

Aunt—"Hush, Tommy! Why do you say that?"

Tommy—"Because I read on some of the tombstones, 'Peace to his ashes;' and they don't have ashes only where it's very hot."—*Ally Sloper.*

# FIBROUS BODIES IN THE TUNICA VAGINALIS TESTIS; WITH A REPORT OF THREE CASES.*

THOMAS S. K. MORTON, M. D.†

I have thought it well to make these remarks upon the subject of fibrous bodies in the tunica vaginalis of the testicle, not only because of the inherent interest of their presence in that locality, but especially to emphasize their significance in determining the method by which the usually coexistent hydrocele shall be treated.

Many excellent text-books ignore the possibility of these bodies existing as a cause or complication of hydrocele, yet three cases have occurred in my practice within two years, and a search of the literature has demonstrated that they are by no means very rare. They may exist singly or in numbers; attached to the tunic or lying loose in the hydrocele sac. In size they vary from a pin-head to half an inch in diameter, although but one case is upon record of the latter dimension. The usual weight is from a fraction of a grain to five grains. In shape these bodies are generally smooth and polished like small beans, but may have become irregular by aggregation of two or more separate formations. A little pit or cup-shaped depression, when existing upon one side, is supposed to represent the vestige of a former pedicular attachment. Le Groux has recorded an instance where the body was cubical. In color they vary from white to dark yellow or red. In consistency, when fresh, they are usually firm and elastic, much resembling fibro-cartilage. When dry they become very hard and stony. These bodies have often been mistaken for bone because of calcification having taken place; in fact, this is a frequent degeneration. Yet some have unquestionably been proved to contain true bone. Usually but one body is found, but as many as five have been discovered in a single hydrocele.

There is reason to believe that loose bodies in the tunic almost invariably take origin from the walls of the sac, and particularly from those portions of the wall which invest the testicular surface. I have found reference to no case in which other origin has been proved. But, of course, the possibility of inflammatory bodies being formed in other portions of the tunic and being subsequently obtruded into the cavity must be acknowledged, as also must be granted the possibility of blood being effused and afterward becoming agglutinated into a fibrous or calcareous free body. It is likewise a possibility that the fluid of a cyst of the tunica vaginalis might precipitate certain of its contents and thus form the nucleus of a foreign body.

Too many observations are upon record to doubt that very many fibrous bodies take origin from the Müllerian duct and its extremity, hydatid of Morgagni, and from that portion of the tunic in the neighborhood of the junction of the testicle and epididymis. They may be found in the layers of or beneath the tunics or be attached thereto by a pedicle of varying length and breadth. Reclus observes that they may very rarely be hidden in a pocket in the tunica vaginalis with a small opening communicating with the sac cavity—from whence they may be shot out by pinching if not attached by a pedicle. Encysted blood-clots (see Case II.) may likewise exist in the tunic, but have no opening into the main hydrocele sac.

Usually the bodies under consideration are found in small hydroceles, but rarely in large collections of fluid. It is presumable that many hydroceles are directly caused by the irritating presence of the bodies. Loose and pediculated bodies have also been found where there was no accompanying fluid. They are unknown in early life and are very rare before puberty.

The fluid of small hydroceles containing bodies is apt to be of a yellowish or brownish color and viscid consistency, and even a bloody effusion may be present. Signs of recurrent or chronic inflammation, such as thick walls, fibrous bands passing between various portions of the interior of the sac, and perhaps multi-

* Read before the Philadelphia County Medical Society, January 10, 1894.

† Professor of Surgery in the Philadelphia Polyclinic; Surgeon to the Out-Patient Department of the Pennsylvania Hospital; Assistant Surgeon to the Orthopedic Hospital.

loculation due to fibrous inflammatory webs closing off portions of the vaginal wall, are often found to coexist with these peculiar bodies, especially where tapping or attempts at radical cure by irritant injections has been previously resorted to.

Upon section the bodies are generally found composed of concentric fibrous layers. These layers may be separated by colored lines due to deposit of blood pigment. The centre has occasionally a solid fibrous or calcareous nucleus; again, it may contain fluid or simply a dry cavity. The fluid, when present, may originate from the cystic interior of an hydatid of Morgagni or be derived from a blood-clot. Bodies have also been found completely calcified. It is possible for them to originate as true dermoid cysts or to have elements of such inclusive remains for a nucleus. Thus Lange has reported a case in which he found two long hairs growing from a hydrocele sac, and others have recorded true dermoid cysts as well as free portions of true bone and cartilage in connection with hydroceles.

The ultimate derivation of these bodies, which for want of a better name have been termed "loose," "fibrous," or "strange," is of great interest and has received much thought from the time of Morgagni, who first observed, described, and named them, down to the present. The Cohnheim theory of inclusion of fœtal tissues is at present the most widely accepted theory of the origin of the true "loose" bodies. Other varieties of bodies result from inflammatory deposits in the layers of the sac; almost always in the neighborhood of the globus major. These undergo fibrous and perhaps calcareous degeneration, become pediculated, and ultimately float free in the hydrocele upon rupture of the pedicle. Another method of origin is the formation of fibrous projections from the tunica vaginalis in the form of small papillomata of the endothelium, which later may become pediculated and subsequently free. This is the multiple variety, of which great numbers may be present. Blood-clot and other direct precipitations may, as has been said, originate another variety of the bodies. There are many instances recorded where the tunics or underlying tissues have become infiltrated through inflammation, senility, etc., with fibrous or calcific plaques. This variety alone may contain bloodvessels. Here pediculation or desquamation into the hydrocele sac rarely takes place, especially if the albuginea is involved. Sir Joseph Fayer speaks of this variety as of not infrequent occurrence in India, where hydroceles are prone to have very thick walls.

The symptoms indicating the presence of bodies in a hydrocele are vague and uncertain. But when a small cyst is present, giving rise to a sense of heaviness and originating unusual pain, and, moreover, if the walls are thick, or failure to cure by irritant injection has taken place, or if great pain or inflammation has followed tapping, the presence of bodies may be suspected. Free bodies might be observed by the light test, but owing to the usual position of attachment to the testicle it will generally fail. A careful study of the cyst by means of the recently devised electric hydrocele illuminator of Otis would certainly facilitate the search if the walls were translucent and the fluid clear.

Granting the presence of one or more bodies, it is probable, if not positive, that nothing short of incision of the sac and their removal will prevent recurrence of the hydrocele. My strong individual preference, as elsewhere stated at length,[1] in the treatment of such hydroceles is to split the sac to its full length, remove the bodies, curette any additional cysts, suture the edges of the sac to the edges of the wound margins, and pack with iodoform gauze until healing by ganulation takes place.

Case I. An Italian, aged thirty-seven years, was brought to me at the Polyclinic Hospital by Dr. J. M. Malatesta He stated that he had had a swelling of the left testicle for several years, and that it had been twice operated upon in Italy—whether it had been injected he did not know. Pain and a sense of weight were marked features of the case. No light could be seen through the swelling.

In view of the previous failures, the painfulness of the tumor and its failure to transmit light, I determined to incise the cyst and investigate. An incision to the whole length of the sac was made and its walls found to be very tough and thick. the contents presented the usual appear-

1 Philadelphia Polyclinic, September, 1892.

ance of hydrocele fluid. The sac was then inverted by turning the testicle out and the latter organ found to be attached to the base of the tunica vaginalis by firm adhesions which were honeycombed by a great number of subsidiary cysts varying from the size of a shot to that of a large pea. These small cysts were grouped mostly about the globus minor and body of the epididymis, but appeared to have no communication therewith. There were also found on the lower portion of the visceral layer of the tunica vaginalis in the same neighborhood several small calcareous tumors, the largest weighing two grains and well pediculated—about half a dozen in all. They sprang directly from the tunic, and the largest could easily have been broken from its pedicle and become a loose body in the cyst.

The small cysts were all split and curretted out, the foreign bodies removed by scraping, the sac edges sutured to the wound margins, the cavity of the tunica vaginalis stuffed lightly with a strip of iodoform gauze, and an antiseptic dressing applied over all. On the second day the packing was removed, the cavity washed out with peroxide of hydrogen first and with 1:2000 bichloride of mercury solution afterward and the packing replaced. This was repeated every second day until ten days had elapsed, when the cavity had become obliterated by granulations. The wound edges now rapidly cicatrized and approximated. At each subsequent dressing the line of granulations marking the wound were touched with stick nitrate of silver until complete healing was secured. On the fourteenth day he resumed his occupation, and on the twenty-fourth day after operation the last granulation had closed over.

This case illustrates bodies of inflammatory origin.

Case II. German, aged fifty years. Small hydrocele that had existed some years. Pain and weight were prominent symptoms. Transmitted light. Upon incision several cyst-like, somewhat pediculated growths from the tunica vaginalis in the neighborhood of the globus major on the testicular surface were observed. These were in turn cut off by dividing the pedicle with scissors. Free hemorrhage of venous character took place from the pedicles, but ceased as soon as the usual iodoform-gauze packing was inserted. The case promptly recovered and was afterward free of his former painful sensations. The growths proved to be blood-clots undergoing fibrous changes encapsulated by layers of the tunica vaginalis.

Case III. A Russian, aged thirty-eight years. Hydrocele of one year's duration. Much pain, uneasiness, and sense of weight in scrotum. Thinking it a rupture, he has been wearing a truss for some months. Tumor quite small and transmits light freely. Upon making the usual incision a free fibrous body two lines by three lines in diameter, of flattened globular shape, was discovered at the base of the sac. Fluid was straw-colored and amounted to about three ounces. The lining membranes were apparently healthy. Spasm of the dartos in this case prevented immediate packing with iodoform gauze and caused obtrusion of the testicle. This necessitated temporary suturing of the wound surfaces across the testicle in addition to stitching the sac to the wound on each side of the incision. In twenty-four hours the dartos had relaxed and the skin sutures were cut and the packing placed in the much-contracted sac. Prompt and satisfactory obliteration of the sac resulted and the man became entirely relieved of his distress.

This case probably was one of true fibrous or loose body originating from the hydatid of Morgagni or fœtal remains.

Conclusions.—1. Probably fibrous bodies are more frequently present in hydroceles than has been suspected.

2. Probably they rarely originate by hydroceles.

3. Probably their presence occasionally prevents the radical cure of hydroceles by irritant injections.

4. Fibrous bodies are to be suspected in small, painful hydroceles—particularly those which have promptly recurred after irritant injection or where excessive pain or inflammation or both have succeeded the injection.

5. That when the bodies are present nothing short of their removal by incision and through exposure of the interior sac will give relief.

6. That the possibility of their presence is an additional and strong argument in favor of the only thorough and certain radical cure for hydrocele, namely, incision and packing with iodoform.

## THREE SUCCESSFUL CASES OF VAGINAL HYSTERECTOMY.

W. H. WATHEN, M. D., Louisville, Ky.

I will exhibit three uteri removed by vaginal hysterectomy for malignant disease beginning in the cervix, two of which I removed last week. The first was removed a little over a year ago and the woman is now in perfect health with no local evidence of any recurrence. I exhibit this specimen because of that fact, and because it shows a more limited extension of disease than the other specimens.

The disease was limited to the posterior lip of the cervix and the vaginal walls for a half inch, necessitating cutting about three-quarters of an inch behind the cervix nearly to the bottom of Douglas' pouch to remove all the diseased structures. The cancerous disease was curetted away as well as possible before extirpation of the uterus. There was nothing unusual in the operation, but ten days afterward the nurse in giving a vaginal douche injected a pint of bichloride solution into the peritoneal cavity. I do not know the exact strength, but it must have been about 1-3000. This caused practically no trouble and the woman made an excellent recovery. But it impressed upon me the importance of avoiding vaginal injections after vaginal hysterectomy, unless we have, by suturing, positively closed the vault and united the peritoneal surfaces if such can be done. I have since had evidence in corroboration of this fact. I recently removed the gauze forty-eight hours after the operation and the omentum came down to the vulva. This was cleansed and returned with no trouble resulting. I do not believe vaginal injections will do any good and they may do much harm by getting into the peritoneal cavity, forcing necrosed and possibly poisonous structures in contact with the peritoneum. I depend upon drainage by gauze, and when this is removed wash the external parts and entrance to the vagina carefully; then with forceps use dry gauze and wipe out the vagina up to its vault; then re-introduce gauze, leaving to drain. By following this method I have had no trouble, and in fact I have not had for a long while any unfavorable symptoms, the patients going on to an uninterrupted recovery.

No. 2. This is a specimen I removed yesterday one week ago. The woman is now begging me to allow her to sit up; the pulse has remained normal, and I presume the temperature has also, because she has had so little evidence of fever that the nurse has not taken the temperature. She has had no distension of the abdomen and not the slightest evidence of sepsis. In this case you will observe that the disease involved the cervix extending up to the fundus of the uterus, which, of course it was impossible to determine until the operation was done and the uterus cut open. All diseased tissues were taken away by dividing the vagina beyond the diseased line.

No. 3. In the third specimen you will observe that the disease does not extend into the body of the uterus, but is limited to the neck going up to the internal os; still there was decidedly more destruction of the cervix than in the case where it extended into the body, showing that we are unable by any examination to detect how far the disease extends. If we do a high cervix amputation, as is advocated by a few of our good operators, we cannot know whether we have removed all the disease, and the only way of being positive that we do is by total extirpation, which is as easily done as the high cervix operation, and with an experienced operator very little more dangerous, for the immediate mortality of extirpation of the uterus is now with the best men very low—probably not exceeding five or six per cent.

About two and a half years ago I had the misfortune to lose a patient after vaginal hysterectomy, the result of sepsis, evidently conveyed to the peritoneum from the cancerous tissues upon the cervix. I immediately recognized the necessity of removing all necrosed tissues before the operation, so as to avoid the danger of sepsis from that cause, and also the possible danger of cancerous infection of the cut surfaces. Two or three days before the time appointed to perform the hysterectomy I gave an anæsthetic and thoroughly curetted the cervix and the uterine cavity with bichloride solution and tamponed with gauze. After the patient is on the

operating table, having been thoroughly prepared by general baths and vaginal douches, and the vulva having been shaved, the vulva and vagini are again washed with soap and warm water, cleansed with bichloride solution, and the curettage repeated.

I will not go into the details of the operation further than to say that I use my hysterectomy forceps and clamp the ligaments. The forceps are removed within from thirty-six to forty-eight hours, though probably they might be removed without danger in twenty-four hours.

As I have stated, the last two patients have no untoward symptoms, and are now past the danger line; and while they will recover from the immediate effects of the operation, only time will demonstrate whether they will be permanently relieved, and if not, how long before there will be a recurrence of the disease. It has been my experience that nine-tenths of the cases of malignant disease that consult me are beyond operative measures, the disease having extended to structures that cannot be removed or caused general infection. Those cases where the disease arises in the body of the uterus, if treated early, are more favorable in permanent results.

## THE TREATMENT OF DIPHTHERIA.*

G. BENSON DUNMIRE, A. M., M. D., PHILADELPHIA, PA.

There is, perhaps, no subject at this time exciting more and deeper interest in the profession, certainly there is none more important than the management of cases of diphtheria. In this connection some general remarks seem necessary with reference to the ravages of the disease. The excess of deaths over births, which is depopulating the French nation to-day, is largely due to diphtheria. In England it is not confined to the large cities alone, but the rural districts are feeling its scourge.† The same may be said of the United States, where there is a growing dread of the disease and justly so, because of the gradual increase of cases, and deaths as well, which quite an extended correspondence with the different State Boards of Health, also the mortuary registers show, conclusively proving two things: 1, its infectiousness; 2, that the general efforts now put forth to stay its progress are inadequate.

As to its infectiousness in man, this has long since been settled in the affirmative and the question now is, what creature is not subject to the disease? since flying fowl, creeping beast, as domestic animals or pets, are susceptible, and, like flies, have the credit of conveying the disease. The cat's ability to contract and transmit diphtheria to persons has long been observed.‡ Animal susceptibility to inoculations with diphtheria exudate and cultures of the same, has frequently been utilized; making them the experimenting ground by which important data have been obtained; settling the question as to whether diphtheria is primarily a local or a constitutional disease, in favor of the former. This has been proven by the elaborate investigations of Wood and Formad, Klebs, Loffler, Abbott, Welch and many others. But for the specific cause of the contagion we are indebted to Loffler for his discovery of the diphtheria bacillus, which bears his name. And no less important are the investigations of Abbott and Welch, who have established the fact that in the Loffler bacillus, we have the etiology of diphtheria, a factor of paramount importance in regard to its rational treatment and prophylaxis, again to be referred to.

With reference to the present effort not being adequate to stop the progress of the disease, we have to say that while this is true generally thoroughout the States, we are glad for one single exception which stands out conspicuously and alone, and is worthy of our respect and emulation. We have reference to Michigan and its State Board of Health, backed as it is by legislative enactments, not only requiring

* Read in the Section on Diseases of Children, American Medical Association, 1894.

† Thorne Thorne's Work. England.

‡ Noah Webster's Epidemic and Pestilential Diseases.

scientific investigative of disease and tabulating the same, but by an enforced system of isolation and disinfection, which has reduced, in 1889, the average number of cases per outbreak from 11.66, in which isolation and disinfection was negelected, to 1.56 when it was enforced, and deaths were reduced from 2.65 to 22,§ showing very plainly that the disease cannot only be controlled, but that there is a possibility of stamping it out entirely. Until other States are guided by the State of Michigan, they will continue to write large bills of mortality; which brings us to the vital question of

ISOLATION.

In the management of cases of diphtheria, after what has been said it seems unnecessary at this date and time to do more than refer to the excellent restrictions and preventions, even to minute details, issued and gratuituously furnished by a number of the State and local Boards of Health. But the great necessity is to have *enforced isolation.* Isolation, if not efficient, is no isolation at all. For instance, to quarantine the house is not isolation, when there is only a board fence or a wall to scale, between the quarantine and coverted liberty. Neither is it isolation, even against the physician's protest, for a mother of a poor family to separate and nurse one of her children sick with diphtheria in a down stairs, badly ventilated room, from the vitated atmosphere of which she emerges to supply the others with the food which the husband is compelled to be absent to provided; for soon the whole family becomes a prey for the disease. To meet such an emergency one of two things is necessary; a nurse must be provided by the health authorities, or the patient removed to a hospital adapted especially for contagious cases. Hence the great need for the latter, and provision for the former. Therefore, to have efficient isolation we must have the State's legal enactments and popular support, as well as public and private cooperation, all of which will follow in the wake of an enlightened judgement and a just appeciation of the great responsibility which one individual owes to another, and the public at large.

In view of the importance of isolation, as well as the trouble and inconvenience attending, the questions arising, What cases shall we isolate, and how shall we discriminate? are immediately forced upon us. Some cases of sore throat having an exudate are contagious and some are not. Under such circumstances it is always safe, particularly during an epidemic, to look upon all such with suspicion and treat the same as diphtheria, at the same time securing some of the exudate for microscopic examination, to determine as early as possible its true character.

The Klebs-Löffler bacillus is the only micro-organism always and persistently present in the exudate which, if found, establishes the diagnosis.‖ To do this satisfactorily will require a microscope with a one-twelfth oil emersion objective, and in some cases the bacillus may be detected by simply straining from one-half to three-fourths of an hour a film of exudate previously spread on a cover-slip in a 2 per cent. aqueous solution of gentian violet, wash in a 5 per cent. solution of acetic acid, then in distilled water, dry in air and mount, preferably, in Canada balsam.* This plan, however, may be confusing just at a time when it is desired to be positive. To establish which, the inoculation of a culture fluid with a portion of the exudate will be necessary, which after about eighteen hours in the incubator, if successful, will under the microscope reveal the character of the bacillus, which culture, if desired can be used to ascertain its pathogenic properties by inoculating a rabbit or guinea pig. If the practitioner is fortunate enough to possess a good microscope, culture incubator and other appliances, he may possibly settle the question in doubtful cases. If not he should send a sample of the exudate on clean, white paper, securely bottled, to a competent bacteriologist, who can in twenty-four hours determine its nature. Every Board of Health should have such a salaried appointee to carry out such investigations. It having been determined that the case is one of diphtheria the patient is isolated, if he has not already been, in the upper story of the house which has been previously cleaned and divested of all drapery, upholstery, carpets and everything excepting the barest necessities for the proper

§ Restriction and Preventions of Diphtheria. Michigan State Board of Health. Printed 1892.

‖ Annual address on the Causation of Diphtheria, by Wm. H. Welch, M D. Transactions of Medical and Chirurgical Faculty of Maryland.

* Loffler's Method.

care and comfort of the patient, and at the disposal of the attendants, for more than one will be required in severe cases.

They should be furnished with one or more large pails containing a 1-1000 disinfecting solution of corrosive sublimate, into which bed linens and garments of whatever character should be immersed before taken from the room. Being free from the rattle of tin, two marked papier-maché basins, one to contain the disinfecting solution before mentioned, as the best in our judgment, and the other for water convenient for the attendant's ablutions after necessary contact with the patient. Two or more covered chamber buckets, one always near containing a quart or more of a solution of chlorinated lime in strength of half a pound to a gallon of water, for the reception and disinfection of alvine dejections and promptly removed from the room, but allowed to remain in the bucket two or more hours before emptying into the closet. In this connection there should be a liberal supply of towels and soap with a view to the absolute cleanliness of the person and the surroundings. A spitting cup containing an 8 per cent. solution of carbolic acid to receive the secretions and expectorations from the mouth, throat, lungs and nose; or a better plan is to receive such material on soft muslin rags, toilet paper or small squares of cheese cloth, immediately burned. Hence, the necessity in the room of an open grate, or stove, in which such expectorations can be cremated. Such secretions being the most infectious, because containing the diphtheria bacillus, should be most carefully guarded and utterly destroyed. In absence of an ordinary stove, a gas or perhaps the objectionable coal oil stove, on which, with a view to prevent dryness of the air in the room and to disinfect the same, a vessel containing the following should constantly be kept simmering, a modification, we believe, originally suggested by Dr. J. Lewis Smith, N. Y.:

℞ Ol. cinnamoni ..... 30 parts
Ol. eucalyp..... .....180 "
Acid carbolic.....220 "
Ol. terebinth..... .....420 "

M. Use one ounce to a quart of water.

An adjoining room should be appropriated to the use of the attendants, to the door of which needed supplies should be brought, and from which disinfected articles be removed for further disinfection with boiling water. The visits to the kitchen by the attendants, where other members of the family are, perhaps children, should not be allowed. To, or in this room, provisions can be brought and prepared as ordered for the patient, which brings us to the subject of

FOOD.

In order to support the strength of the patient, the proper nourishment is a matter of the most vital importance. Though anorexia is generally persistent, systematic feeding should be instituted early, and of such character as is suitable to the age and condition of the patient. Fluid nourishment being most tolerant to the stomach; as milk, warm or peptonized, cold milk, beef juices expressed from broiled beef, beef peptonoids and other food more concentrated, as eggs, soft boiled, eggs and milk; and when stimulants, which are required early in severe cases, eggs and milk beaten up with brandy, also milk punch, should be judiciously given.

In those cases where there is an unwillingness, or as is frequently the case, an inability to swallow nourishment, enemata of the articles just mentioned should be resorted to early, freely and continuously, until convalescence. This cannot be emphasized too forcibly, for by the early and continued support and maintenance of the vital powers, we thereby assist nature to resist and withstand the septic influence of the disease, and thus we often accomplish more than by over-much medication.

LOCAL TREATMENT.

The necessity for seeing diphtheritic cases early cannot be over-estimated, and in our judgment should justify the request, on the part of the family physician, for a speedy summons in time of sore throat epidemics especially; for success in a great measure will depend upon the local treatment being employed early, vigorously and with a view to destroying the diphtheria bacillus and preventing the absorption of the poison, now known to be tox-albumen. To accomplish this desirable result in

PHARYNGEAL DIPHTHERIA:

First, disinfect the throat; and second, remove the exudate as fast as it forms:

To accomplish this, begin by spraying the throat with a 1-1000 aqueous solution

of mercuric chlorid, using one of the many atomizers, or if the child is sufficiently intelligent have it gargle with the same solution, which will make the throat safe to work with, to be repeated every three or four hours. Then by means of brush or cotton swab, patiently and with care dissolve the exudate, by applying the following:

℞ Papayotin or trypsin* ..... gr. lxx
Hydrar. chlo. cor. ..... gr. ¼
Aqua distil ..... f. ʒ iv
M.

Apply every half hour until the membrane is dissolved; and at the same time every half hour alternately, disinfect the throat by using one of our safest antiseptics; the peroxid of hydrogen, though not a germicide†, accomplishes the same result by interfering with the development of the bacillus. Spray the throat, using from one-half to 15-volume solution or full strength, which will aid in dissolving the exudate in its formative stage, but fails to do so later, when imbedded in necrotic tissue, for which reasons these applications should be faithfully applied, not even allowing the patient's sleep to interfere; for very frequently the fate of the case depends upon the first twenty-four hours of local treatment, which if persistently and efficiently done, we have reason to believe that the septic influence of the bacteria may be prevented, and instead of a lingering case, we will have a a rapid recovery of the patient. We, however, cannot afford to confine our remedies to one or two, but suit the remedies to the case; hence, another very valuable and safe disinfectant and good antiseptic successfully used, where the other might be inapplicable, is a ten grain solution of the nitrate of silver. The solid stick or even a too strong solution, makes it difficult to distinguish the resulting coagulated albumen from the diphtheritic exudate; besides, we have thought that its frequent application tended or predisposed the inflamed mucous membrane to a necrotic condition finally resulting in hemorrhage.

The forcible removal of the exudate and the application by means of cotton wrapped on a pincett, of the following:

℞ Camphor ..... 20 parts
Castor oil ..... 15 parts
Alcohol ..... 10 parts
Carbolic acid ..... 5 parts
Tartaric Acid ..... 1 part
M.

* The best at our command.

† George M. Sternberg, M. D., on Disinfection, Hare System of Practical Therapeutics.

is recommended by Grancher‡ also Dr. Turner of Glasgow, suggests a similar treatment but uses the application of parafin. Being painful the treatment though successfully used in adults, is inappropriate with children, and further the danger of absorption from the wounded surface would be increased. The same objection would apply, it seems to us, to Dr. August Seibert's disc of hypodermic points, through which chlorin water is injected to destroy the bacillus, as it is now known that the bacilli are mostly on the surface of the membrane.

Since the use of corrosive sublimate, first by Billotte in 1876, it seems to be growing in favor. Rennert, of Germany, reports repeated successes, by wiping off the exudate with the following:

Hydrarg. chlo. corrosiv. ..... 1 part
Acid tartaric ..... 5 parts
Aqua ..... 1000 parts

The remedy is being largely used in England.

In very young children, the repeated insufflation of washed sulphur, an application which can be thoroughly made where we fail with many other applications, by simply using a glass tube. The good resulting may be attributed to the disinfecting properties of sulphurous acid, set free by the oxidation of the sulphur.

As a topical remedy, we have used the perchlorid of iron in combination with glycerin, equal parts. In hemorrhagic cases it does well. With many it is the principal local treatment.

Carbolic, boracic and salicylic acid, have their appropriate use as antiseptic gargles and sprays, but as every intelligent physician has his own way of using means to ends, these, with many others, if time permitted, could be named as suggestive of the fact that it is unwise to restrict our remedies, but treat each individual case, not the disease. Keeping in view and preventing if possible, the tendency of the disease to extend to the larynx as well as to the posterior nares. If to the latter we have

NASAL DIPHTHERIA.

The nasal passage may be the primary seat of the disease; frequently, however, it is the extension of the pharyngeal affection. This complication is recognized by the forced mouth respiration, the nasal passages being closed by the swollen mucous

‡ Le Progress Med., Sept. 27, 1890.

membrane which is covered with a grayish white lining, discharging a thin acrid muco-purulent discharge which, later on, becomes greenish-yellow tinged with blood.

The glands in the neck soon become involved, with earlier constitutional involvement than in the simple pharyngeal variety. These unpleasant cases are difficult to manage on account of the intricate nasal passage which should be disinfected early by douching and spraying the nasal fossæ.

The former can best be done by means of a perforated flexible rubber catheter, attaching the same to any ordinary syringe, and by bending the patient's head forward, the nasal cavities can be thoroughly and effectually douched, preferably with the peroxid of hydrogen, every three or four hours.

The nasal passage may be sprayed with the same remedy, also with a weak solution of carbolic acid, or the corrosive chlorid, but some instructions to the inexperienced attendant will be necessary to the careful introduction of the nozzle of the atomizer, keeping it on a level with the floor of the nasal fossæ and parallel with the septum, so as to prevent wounding and the resulting hemorrhage. The greatest cleanliness should be observed in these cases, using the 1 : 1000 chlorid wash, and the cremation of all nasal discharges. But as intimated the exudate may extend to the larynx and the result is the most dangerous phase.

### LARYNGEAL DIPHTHERIA.

Though the duality of membranous croup and diphtheria is not absolutely settled, yet the fact of their unity being so regarded by physicians generally and acted upon approvingly by boards of health, is accomplishing good as a check to its spread. The bacillus may primarily attack the windpipe, but, like the nasal form, it is frequently the extension of the disease into the larynx. Its commencement may be recognized by a hoarse croupy cough with aphonia, and later a gradually increasing dyspnea. These symptoms sometimes subside in a few days under the internal treatment of bichlorid and spray of the same from a steam atomizer, also lime water and 2 per.cent. solution of carbolic acid, or the steam from lime slacking in any ordinary vessel having a perforated lid, to which a tin tube or pipe can be conveyed into a tent constructed over the child—not forgetting proper ventilation—or to the mouth of the patient. We cannot expect, however, as much from our spraying and local applications which are so beneficial in the laryngeal and nasal form of the disease. In this connection and in this form of the disease, we wish to call attention to a remedy the results of which have been recently so satisfactory as to justify further trial, namely, oxygen. It should be given early because of the better oxidation of the blood. The increased tone and strength, both to the nervous and muscular system resulting from the improved condition of the blood, allays nervous irritation and excitability and produces sleep, all of which tends to assist the vital powers of the system to battle with the disease. Three inhalations in succession of about twenty seconds each, allowing the gas to pass through a jar of antiseptic water, should be given three or four times daily, or oftener, when there is labored breathing or a cyanotic condition. But should the dyspnea increase, preparation will have to be made to intubate or perform tracheotomy, which leads us into the domain of surgery, upon which it is not our purpose to enter, further than to state that either operation gives the patient about equal chance. Dr. Stern makes the per cent. of recoveries of the former 26 2-5 per cent. and the latter 26½ per cent. The same author recommends intubation under three and a half years of age, and after that time the preference is for tracheotomy, excepting adults. Dr. Montgomery, however, who has had a large experience in intubating, writes us that he has had 44 per cent. of recoveries. But in our treatment we should not forget

### CONSTITUTIONAL REMEDIES.

Just how soon the poison of diphtheria is taken up by the absorbents, and how much or how little is required to contaminate the system, we have no reliable means of determining. That it is absorbed very rapidly we have only to recall the cases in our experience of heart paralysis after a few days of illness, and the amount to produce septic influence may depend largely upon the susceptibility of the person. But Welch and Flexner have shown that 2 cc. of filtered culture fluid contained toxic properties sufficient to kill a guinea-pig. So it is well to begin internal remedies early,

and we can make no mistake by giving the chlorid of iron and quinin in large doses suitable to the patient three or more times daily, so as to obtain not only the tonic effect of both, but the antiseptic influence of the iron; or alternate or substitute for the iron the following:

℞ Hydrar. chlo. cor.....grs. jss. (1½)
Syr. aurant rub.....
Aqua ää.....f ʒ j.
M.

Take from one-half to a teaspoonful every six hours. The object being as Dr. Jacobi suggests, "to have its specific counteracting effects on the diphtheritic poison in the system."

Chlorate of potash is looked upon with less favor than formerly, because of its unfavorable action upon the kidneys.

Complications or sequelæ of diphtheria in the form of paralysis of the uvula, arms, or legs, can best be relieved by general tonics, change of air; we have found a sojourn by the sea of great benefit. Obstinate cases yield to hypodermic injections of strychnia, from 1.20 to 1.60 gr. three times daily. Electricity will also be of service.

Instead of summing up conclusions, allow us to say a word in reference to our future hope—

PROPHYLAXIS.

1. Against personal infection, physicians and attendants should gargle the throat, wash the nasal passages, face and hands before and after visits, in 1-1000 solution of corrosive sublimate, and nothing short of a change of garments is excusable in going from a diphtheritic case to other patients.

2. This paper would be more incomplete than it is, did we not refer to what modern bacteriologists are accomplishing for us, particularly concerning the prevention and cure of the toxic products producing the morbid symptoms which we more or less see in every case of diphtheria.

Dr. E. A. De Schweinitz, Biochemic Laboratory, Washington, D. C., replying to our query, writes: "Experiments in this country and abroad have demonstrated that a substance (albumose) exists in and can be isolated from the cultures of the diphtheria bacillus which produces, when injected into guinea-pigs, immunity in those animals from this disease." Hardly had we begun to ask the question, why can not this immunity be safely rendered to man? when we learn from Germany that "blood serum" from immunized animals is an anti-toxine which gives immunity to the individual, and that Dr. Aronson, of Berlin, claims for his blood serum immunizing strength of 1-10,000 for guinea-pigs; for children weighing forty-four pounds; 4 ccm. given subcutaneously, which doses afford positive protection if injected before infection; being inefficient in the disease's later stages.

But "later investigations, particularly Behring, have proved that this property of blood serum to counteract the bacterial poison may be progressively intensified, so that by repeated inoculation, a complete immunizing strength can be obtained, potent even against super-virulent bacteria cultures. The injection of blood serum from such animals afforded not only protection against virulent infection, but aborted the already present infection and made it harmless, and therefore proved *a specific cure* for the indicated disease." If these facts can be established in this country and elswhere, surely the "goal of therapeutic effort" is reached and the glory for the second Jenner is in reserve.

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A Long Fast.—Russian newspapers report the case of a girl, seventeen years old, who was overtaken by night, and being afraid to go home in the dark, decided to pass the night under a *hangar* covered with a little straw. During the night a snowstorm occurred, and in the morning the girl found herself unable to escape from the load of snow which covered her. The first day she ate five morsels of bread which she had with her. After that she had no other nourishment than the snow which imprisoned her. It was not until the end of *fifty-one days* that she was discovered and taken to a hospital. Although unable to move, she could answer questions. She made rapid progress, and at the end of the first week could take the ordinary diet of the hospital.

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Conceptions just previous to the menstrual period result in boys; those just after, in girls. Such is the conclusion from many observed, notably among the last by Dr. George Abbott, who publishes his opinion in the *Medical Record.*

# TRANSLATIONS.*

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.

### IN-GROWING TOE-NAIL.

Dr. C. Huebscher, (*Correspondenz-blatt f. Schweizer Aerzte*, No. 54, 1893), observing that neither removal of the nail nor excision of the lateral grooves will hinder recurrence of in-growing toe-nail, while local application of caustic potash is not radical and excision of the whole bed is apt to be succeeded by a granulating surface that requires time to heal and is liable to try the patient's patience, has tried to overcome this difficulty by removing the entire bed of the nail and covering the defect by a skin flap according to Thiersch, in order that healing follow by first intention. He proceeds as follows: an injection of a cocaine solution is made into the toe, the nail is split and both halves evulsed, the two lateral folds cut out and the posterior portion excised that an even and fresh wound surface result. The whole bed of the nail is then freshened up with the knife held on the flat. The hemostatic bandage is then loosened, the hemorrhage controlled by means of a tuft of gauze and a thin layer of skin cut from the surface of the thigh and transferred to the wound. As a dressing, strips of gauze, dipped into a solution of iodoform in olive oil, are employed, over this cotton and then gauze. The patient is kept in bed and after two to three days the dressing is then changed. Healing usually takes place, by first intention. A protective against friction may be given by covering the toe with an investment of iodoform gauze and collodion.

### TREATMENT OF ABORTION.

Dr. Czempin, (*Wiener Medizinische Presse*, No, 44, 1893), warmly recommends prophylaxis for, in spite of hemorrhage, the fetus may still be able to continue its development. The greatest quiet, and above all, rest in bed are to be observed during the time corresponding to the menstrual epoch, for then the inclination to hemorrhage is greater. A cause less frequently thought of as inducing abortion, is the existence of cicatricial adhesions binding the uterus to its surrounding tissues and organs, after preceeding pregnancies; cervico-vaginal lacerations and their cicatricial adhesion to the surrounding tissues and the residua of parametritic exudates. Abnormal fixation of the uterus to the lateral pelvic wall may also hinder the organ in rising up into the abdomen, in the third and fourth months. Violent colics are thus produced which can not be traced to any palpable cause, and are often difficult of explanation. The influence of the interabdominal pressure, with the movements of the body, lead to hemorrhage into the mucous membranes and consequent abortion. Even under such conditions, by rest in bed and care, one may surmount this critical period in the third to the fourth month. Treatment must consist in removing all the harmful influences. Three classes of abortion may be distinguished:

Incipient abortion.—The fetus and placenta are yet retained in the uterine cavity in spite of pains and hemorrhages.

Incomplete or protracted abortion.—The fetus is expelled and the placenta or portions of it are still retained. Here there are liable to be severe hemorrhages or ill-smelling discharge and fever.

Complete abortion with hemorrhages from the mucous membranes. The fetus and placenta are expelled, the uterus slightly enlarged, with continuous slight hemorrhages or bloodily tinged serous discharges, from incomplete throwing off of the decidua.

The first group, which is relatively rarely observed, demands careful expectant treatment, and with severe hemorrhages, acceleration of expulsion. Tamponading the cervix, with strips of iodoform gauze, will both dilate and excite contractions. Introduce them up above the internal os and if necessary renew the proceedure. Manual evacuation, if called for.

The second class is the most frequent and dangerous. The severe hemorrhage, with the succulent, soft and enlarged uterus and the open cervical canal, call for immediate digital evacuation of the uterine cavity. If the cervix be closed, dilate. The dull curette should only be employed after previous dilatation and the sharp

*Translated for The Medical and Surgical Reporter by F. H. Pritchard, M. D.

curette never. Ergot is here contra-indicated as residua, even if of large size, are not influenced by strong contractions. He recommends tamponade for twelve hours before evacuation, as it causes softening of the cervical tissues and greatly facilitates forcible dilatation. If there is neither severe hemorrhage nor fever, employ the gauze tamponade, otherwise force dilatation. This is best done by introducing a Simon's speculum, fixing the cervix with a tenaculum and slowing introducing Hegar's dilators, under anesthesia, if necessary. When the cervix easily opens up, the finger is introduced, all portions of the uterine cavity are searched over and the placental residua removed.

The third group is often too energetically treated, for spontaneous expulsion often follows later. Even if none of the secundines are cast out, one may safely wait twenty-four hours in recent cases. The firmly contracted uterus shows that the placenta is expelled and that only the decidua remain. The dull curette may be employed without dilatation. In the greater number of cases a few doses of ergotine will generally suffice to induce their being expelled. It is injudicious to curette after each and every case of abortion without having examined the parts thrown off.

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### CONFUSION OF GASTRIC AND INTESTINAL DYSPEPSIA.

Prof. Germain See (*La France Médicale*, No. 52, 1893) claims that a third of those patients who were thought to be dyspeptics and of stomachic origin are actually sufferers from intestinal disease. This holds good especially, in women, for a careful examination both by physical and chemical diagnostic measures reveals good gastric function and no dilatation, while they have gone from one physician to another and have been treated for dyspepsia. These dyspepties are not suffering from a gastric disease, for their whole trouble lies in the intestine and pre-eminently in the large intestine. It deserves the name of muco-membranous enteritis. The small intestine in such cases is healthy. This muco-membranous enteritis is characterized by disturbances in the functions of the colon, gaseous fermentation, dilatation of this intestine, but nothing reveals it with certainty other than the passage of mucous glairy, ribbon-shaped or cylindroid masses, with the feces often unperceived. These mucous products are also frequently accompanied by the hardened residua of undigested food. Treatment consists in evacuation by mechanical means, as olive oil or senna, but not by purgation, calming the pains by the bromide of calcium or strontium or cannabis indica but not by opium and its preparations. Fermentation and the formation of gas may be limited by the phosphate, the biborate or the salicylate of soda, never by benzo-naphthol. The diet is that of one in health except that the presence of habitual constipation or incidental diarrhœa alter it. In general, hearty foods as ham, pork, game, boiled eggs are easily digested, while milk is tolerated with difficulty. Potatoes, either mashed or boiled, as well as rice, are easily digested though fruits are of no advantage. Water and tea are permissable as beverages. Gaseous waters are contra-indicated on account of their containing carbonic acid gas. Alcohol, being in large measure absorbed by the stomach, is best left alone unless temporarily, when digestion is bad. Then a hot sling is of service, while red and white wines are not to be allowed.

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### NITROGLYCERINE IN POISONING BY ILLUMINATING GAS.

Dr. Hoffmann (*Deutche Medicinsche Wochenschrift*, No. 50, 1893) has employed subcutaneous injections of nitroglycerine in cases of poisoning by illumination gas, with the best of results. He injects from one hundred and twentieth, to an eighth of a grain every twenty minutes. Others have confirmed this.

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### GONORRHŒAL CYSTITIS.

Dr. Okeblom (*Deutsche Medicinische Wochenscrift*, No. 35, 1893) in cases of cystitis, and more especially where it is of gonorrhœic origin, injects every second to third day, one to six grams—fifteen drops to one and a half drachms—of a solution of iodoform in ether and olive oil—1:7:7—by means of a Guyon syringe. The pain and tenesmus cease at once.

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### UNTOWARD EFFECTS OF IODOFORM.

Prof. L. Lewin (*Hospitals-Tidende*, No. 31, 1893) devotes an extensive article to

the side and after-effects of iodoform. On the skin, in some cases acne and purpura, have been noticed after its internal use. Cutaneous symptoms are frequent and are chiefly, though not entirely, due to its local use. Local dermatitis is the form most often noticed, though it may extend more or less over the body in exceptional cases. This eruption may be either eczematous, vesicular, pustular, impetiginous, or erysipelatous and often accompanied by high fever. In other cases, extensive erythematous eruptions, with formation of bullæ or purpural patches as well as urticaria or papules have been observed. Intense itching may complicate and the dermal phenomena last for several weeks.

Conjunctivitis, transient amblyopia, alterations in the pupils and strabismus are recorded. Among the symptoms are mental alterations which either exist alone or are the forerunners of graver psychoses. In most cases they assume the form of melancholy, with anxiety, uneasiness of mind, inclination to tearfulness, tiredness of life and restlessness which very frequently alternate with periods of excitement. This may be associated with vertigo, headache, elevation of temperature, sleeplessness and small and rapid rise of pulse. The pulse may, without disturbance of the general health, run up so as to become uncountable while the temperature remains normal. The temperature may also rise and continue for several days at this elevated condition, several degrees over the normal, without the patient experiencing a feeling of illness. This increase of pulse, without accompanying fever, is a threatening symptom in elderly people.

Melancholia, the chief expression of its mental action, when once it has appeared, is prone to persist. It is accompanied by hallucinations, visions, illusions and anxiety which are expressed in the delirium of persecution and in the attempts at suicide. These patients, as a rule at night, but even during the day, suddenly will jump from their beds, try to spring from their windows, to escape or to throw themselves into the water. They attempt to tear off their bandages, destroy the bedclothes, talk confusedly, stamp their feet, rage and do not recognize their surroundings. This condition may last from a few hours to days and pass off into a more morose and tearful state, which soon ends in recovery. They remember nothing of the attack and present pure types of transitory mania. In some cases the depression increases in intensity, and a completely stuporous state of melancholy developes, with refusal to take food, rapid decline and death. Seizures of anxious excitement and choreiform attacks, loss of appetite, and violent vomiting have also been noticed after the use of this antiseptic. In men and animals poisoned with it, no pathological alterations are found in the brain and its membranes, but only fatty or parenchymatous degeneration of the heart muscle, liver and kidneys.

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### ACNE.

Dr. Phillipson (*Hospitals-Tidende*, No. 50, 1893) recommends in acne the following lotion:

℞ Acetic acid,
Tinct. benzoin,
Spirits Camphor, ana..... 6 gms. (℥jss).
Alcohol.....82 " (℥ijss).
Apply locally morning and evening.

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### VINEGAR IN VOMITING AFTER CHLOROFORM.

Dr. Warholm (*Hygiea*, No. 10, 1893) has employed vinegar with success in the treatment of vomiting after anesthesia by chloroform. He dampens a cloth with the liquid and places it near the patient's nose, allowing it to remain there until he awakens, or even longer if vomiting then threaten. He warmly recommends its use.

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### CHRONIC URTICARIA.

In the (*Hospitals-Tidende*, No. 44, 1893), the following salve is advised in the treatment of chronic urticaria:

℞ Chloral,
Powdered camphor,
Gum arabic, aa.....5 gms. (℥j¼).
Simple cerate.....40 " (℥j¼).
Rub in well every evening.

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### ANEMIA IN NEURASTHENIA.

Prof. Gram (*Hospitals-Tidende*, No. 47, 1893) employs the following formula:

℞ Citrate of iron and quinine...5 gms. (℥j¼).
Distilled water..... 200 " (℥vjss).
Brandy.
Syrup, ana.....50 " (℥jss).
A tablespoonful three times a day.

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### GASTRIC SYMPTOMS OF NEURASTHENIA.

Drs. Rummo and Braccini (*La Semaine Médicale*, No. 54, 1893) employ the following formula:

℞ Phosphide of zinc..... 1 gm. (grs. xv).
Bromide of zinc..... 1 " (grs xv).
Bromohydrate of quinine..1.5 " (grs. xxij).
Extract of nux vomica.....15 cgms. (grs. ijss).
For thirty pills. Three per diem.

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SATURDAY, FEBRUARY 10, 1894.

## EDITORIAL.

### INFLUENZA.

"Oh, I have pass'd a miserable night,
"So full of fearful dreams, of ugly sights,
"That, as I am a Christian, faithful man,
"I would not spend another such a night,
"Though 'twere to buy a world of happy days,
"So full of dismal terror was the time."

—*Shake.*

When the present epidemic was beginning to make itself evident in this country, the average physician was prone to regard *La Grippe* as a fashionable euphonism for cold in the head. After a personal experience with the disease, the average physician is apt to remember *La Grippe* as an avalanche of outer darkness, overwhelming the physical energies, paralyzing the mind and plunging the spirit into an abyss of misery that gives a new and vivid meaning to the despairing cry of fallen Lucifer:

"Which way I fly is hell; myself am hell,
"And in the lowest deep a lower deep,
"Still threatening to devour me opens wide;
"To which the hell I suffer seems a heav'n."

Influenza presents probably a greater variety of symptoms and manifestations than any other known disease. On the one hand it appears as a transient cold in the head, while in its graver forms it may strike down its victim with the utmost rapidity, or so completely prostrate his mental and physical powers as to invite insanity and even suicide.

Dr. Guiteras thinks that a safe answer to the question "What is influenza?" would be, "An epidemic cold depending upon some yet unknown cause." This is more general than it is satisfactory, but it is doubtful if a more exact definition can be given.

Guiteras says (*Med. Rec.*) concerning its etiology:

"Predisposing influences, none. People are attacked without distinction of age, sex, occupation, or social standing. Previous or present illness affords no protection. One attack renders no immunity from another. Overcrowded, unhealthy, badly ventilated, and damp dwellings render attacks more severe, although the dwellers are no more prone to it. Influenza may occur in any season. It occurs usually in the autumn, often in the spring, and sometimes in the summer and winter. Latitude has no effect, as in the epidemic

of 1837 it appeared at the same time in England and Cape Colony, that is, in directly opposite zones and seasons. Climate has no influence, as it occurs equally in the dampest and driest regions. Certain meteorological signs and coincident phenomena have been remarked as preceding many of the previous epidemics, such as foul fogs, volcanic eruptions, earthquakes, etc.

"The rapidity with which it spreads and the great numbers who suffer from it at the same time and in the same way, certainly point to some specific poison which is carried by the air as a disseminating medium and excites the disease. This poison was supposed by many for a long time to be the sulphur and other matter thrown from the volcanoes, which was carried about in dust-fog currents, a foul fog having been generally noticed before an epidemic, or accompanying it. In this enlightened age, however, I think we are justified in believing that the exciting cause is a micro-organism.

"The investigations of the bacteriologists in searching for micro-organisms have resulted as follows:

"For several years the diplococcus pneumoniæ of Frænkel and Weichselbaum, the streptococcus pyogenes, the staphylococcus pyogenes aureus, and several scattering forms were the only ones found, until Dr. Pfeiffer, of Berlin, in 1892, discovered a bacillus in the secretions of patients suffering from influenza, which was declared by Koch, Kitasato, and others to be the true germ of this disease. This bacillus was about the thickness of bacillus mouse septicæmia, but only half the length. As only the two ends stain, it is very hard to distinguish it from the diplococcus and streptococcus. Former observers seeing these mistook them for the latter. They were cultivated by Kitasato and others.

About the same time Bruschettini[1] found the same germ in the blood of those suffering from the disease.

The question why an epidemic may break out at one time and then for years remain dormant is not an easy one to answer. It is probable that there are cycles in which peculiar seasons recur, and that such cycles are associated with the reproduction of similar disordered conditions in the health of man."

It occurs to us that influenza, at least in the more marked nervous forms of the disease, is essentially a neurosis of the central system, or else in these forms the bacillus or its products exercise a peculiarly toxic effect on the upper spinal system. This is on the assumption that the disease is essentially a germ disease, although the life history of the specific germ has not yet been declared.

By far the most common form of the disease is that in which the catarrhal symptoms predominate, and though protean in its manifestations, its sequelæ are not as disastrous as are those of the distinctly nervous type.

The prognosis, as regards life, is good in most cases. The disease is self limited, and with suitable treatment and proper care on the part of the patient, there is little doubt of speedy recovery. In the old and infirm, in those suffering from chronic diseases, in patients with Bright's disease or valvular disease of the heart, influenza is dangerous; very frequently fatal.

Treatment must be directed to the symptoms presented by each individual patient. On general principles, the bowels must be kept soluble; headache, fever and pain controlled by suitable drugs, but with the careful avoidance of such as tend to depress; stimulants must be used where necessary, but never in excess; while the system must be supported and built up by tonics and foods. Other indications must be met with as they rise. But there is one thing that should be im-

1 Ricerche bac. sull. infl. la communicazione preventiva. Riforma Medica, Gennaio, 1892.

pressed on the patient's mind. Influenza is a disease not at all amenable to the will power of the individual. Attempts to combat it by the exercise of will are only wasted energy, and the best means to insure a speedy recovery is absolute rest in bed from the time the disease makes itself evident, until the system has become habituated to its presence and has recovered itself enough to resist its inroads.

# ABSTRACTS.

## SOME THINGS THAT SHOULD NOT BE FORGOTTEN BY THE GENERAL PRACTITIONER.

B. C. KEISTER, M. D., South Boston, Va.

First, he should recognize his duty to himself, and second, his relationship to other physicians. I believe it was the late Dr. Flint who made the remark that "every physicians who is true to himself should be a thorough gentleman, a through business man and a thorough physician."

First of all, he should be in sympathy with the Christian religion; even if he is not a member of any special branch of the orthodox church, he should certainly not be a skeptic or an infidel. It would be exceedingly difficult for a skeptical physician to hold the confidence of one of his church-going patients through any serious illness, to say nothing of the many other disadvantages, under which he would have to labor. I may be pardoned for saying that we have in our ranks, men who are not only skeptical on religion but *peculiarly* so on the science of medicine. They delight to speak disparagingly of the science and are fain to show an air of ostentation that well characterizes the peacock or the *non compos mentis*. This latter class of physicians, to say the least, are unworthy of the title they bear; for to them is due the skepticism that exists among the laity on the science of medicine, and thus a great barrier is formed between physician and patient, to say nothing of the harm done to the credit of the profession. It is true there are wonderful changes constantly being made in the art of medicine, but generally speaking, these changes are only the steps toward a better and more perfect practice of the science. As man's constitution changes so must our practice change, in order to adapt its merits to man's necessities. Medicine is a progressive science. The advance that has been made in the past ten years in the science of medicine and surgery far surpasses that of all other branches of knowledge. Dr. Nicholas Senn, who is one of the progressive surgeons of the world, remarked to a large body of physicians a few months ago, that there had been more genuine progress made in the science of surgery within the past ten years than had been made during the previous one hundred years. Thus we see how grandly our great science is keeping abreast with all others, and I may add, since antiseptic surgery and electricity have come to our aid, we are fast outstripping all other professions on the broad road of progress.

All honor to such men as Koch, Pasteur and Sternberg, who have accomplished wonderful results in their researches with the microscope, in ascertaining the cause of disease. All honor to such men as Senn and Gerster, Loomis and Osler for putting into practice the teachings of the former, and thus bringing about a grand revolution in the practice of medicine. It is the duty of every true physician to hold up the standard of his profession. And to do this successfully, he should be both a thorough gentleman and a thorough physician. He should keep abreast of the times, by spending at least three months out of every three years at the medical centers, where hospital advantages are offered to the general practitioner as well as to the specialist. This is a duty that every true physician owes to himself. If every general practitioner would do this, he would be better prepared to do his work, instead of allowing his patients to go to the city

specialists to be treated for the very disease that he could have treated equally as well at home. It is passing strange that there are so many general practitioners, who from mere want of confidence in their own abilities, will send their patients to the cities to be treated by men who have had less experience and fewer collegiate advantages than they have had. I am acquainted with a physician who sends at least one-third of his cases to the city to be treated; these, doubtless, could be treated at home just as well. I claim that there is but one advantage the prominent city physician has over the town or country physician, namely, the hospital advantages, where good and skillful nursing is required after capital surgical operations. We need a few more McDowell's and Sims in the country villages to encourage us to compete with the city surgeons and city specialists.

I long to see the day when every village and country doctor will be as handsomely equipped in office facilities, etc., as any city specialists, and thus be prepared to treat his cases at home, instead of sending them with their pockets full of money to the city specialist. I am proud of the fact, that out of a yearly three thousand dollar office practice, I have thus far been able to treat my cases at home, and I mean to continue to do so as long as I remain in the practice of medicine. There is no just reason why every physician should not keep abreast of the times as above indicated, and be equipped with a full supply of the necessary surgical instruments, galvanic, faradic and cautery batteries, etc. There are many lives sacrificed, wholly on account of the attending physician not having proper surgical instruments to relieve the patient. To cite an instance of this kind:

About four weeks ago I was summoned fifteen miles in the country to relieve a man who was suffering from suppression of the urine, due to organic stricture of the urethra. The attending physician, who is a very clever man and a good doctor, did not have a urethrotome or any suitable bougies by which to relieve the patient of his intense suffering, and he had not passed scarcely any urine for the previous thirty-six hours; doubtless he would have died very soon from rupture of the bladder or uremic poisoning had he not been relieved. The pay received in this one case would have been sufficient to purchase two or three urethrotomes and a sufficient number of filiform bougies to last five years.

I claim that in nine cases out of ten it is *sheer stinginess* on the part of the physician, that he is not properly equipped with suitable instruments. Every physician should have in his office one good twenty-four cell galvanic battery, two good faradic batteries and one good galvano-cautery battery, ( I like McIntosh's batteries better than any other make). If he has studied electro-therapeutics and can master it well, he will find it a wonderful help to him in the treatment of diseases peculiar to women.

I am very much inclined to believe, that in the course of time electricity will take the place of the surgeon's knife in gynecology. I can testify to its proficiency in the treatment of fibroid tumors of the uterus, subinvolution and many other diseases of this class. Conservative surgery is yielding better results every day, and I believe the time is not for distant when women's ovaries will be let as severly alone by the abdominal surgeon as the Holy Bible. Away with the idea of a physician's reputation being gauged or made by the number of laparotomies he performs or the number of women he unsexes. It was my privilege a few months ago to be an eye witness to some ten or twelve laparotomines, and I must say, with all due deference to the skilled operators, that in my humble judgement, at least two-thirds of those poor women would have been far better off without the operation. I may cite one case in particular, that had been diagnosed cystic disease of both ovaries, but on opening the abdomen and close examination the cystic disease failed to show up. The operator, however, thought it best to remove the ovaries lest the disease should show up later on. Now, this simply shows how a thing may be run into the ground by the sheer craze for reputation. There were some fifteen or more other general practitioners who witnessed this operation with me, and it was interesting to see the exchange of frowns from one to the other during the later part of the operation. The skilled professor tried very hard to justify his theory for castrating this poor woman, but it failed to have the desired effect upon those who were present. The

main symptom complained of by this woman was pain in the region of both ovaries at each menstrual period, with some irregularity of her menses. I claim that such cases can be relieved, if not cured, by medicines and electricity. Dysmenorrhea with narrowing of the internal os of the uterus can be successfully treated by three applications of Goodell's uterine dilator, followed each time with six minutes intra-uterine electricity by the faradic battery. I have never failed to cure a single case where this treatment was adopted.

I was very favorably impressed with the remark made by Prof. Bangs of the Chicago Policlinic, in one of his lectures on gynecology, when he said, "that after some fifteen years of active practice in his *special* branch, he had come to the conclusion that three-fourths of the diseases that women suffer from were due to constipation of the bowels." He also remarked in one of his lectures on cervical lacerations, "that three-fourths of these lacerations were almost harmless, and hence did not require operative procedures and that conservative treatment yielded far better results in such cases."

Thus we see, there is much for the general practitioner to consider before allowing his female patients to go off to be treated by the city specialist. There is no plausible reason why the general practitioner should not do as good work and get as good result in the majority of such cases, provided he has as well equipped an office as the city surgeon or specialist. In doing this he not only saves his reputation from being at the disposal of the criticising city specialist, but of equal import he saves hundreds of dollars that would otherwise leave his own needy pockets for those of the specialist. There is no reason why the general practitioner should not operate for cataract, or perform iridectomy, or remove a nasal polypus, or do any other work that he is called upon to do in the science of surgery and medicine, provided he keeps abreast of the times and is properly equipped for his work. He should consider that the city specialist's opportunities for acquiring knowledge are just the same as those of the general practitioner, for both sit side by side in the lecture hall, and hear the same lectures and witness the same operations in the same amphitheaters. It is no less the priviledge of the general practitioner to take special courses at the post-graduate schools at the great medical centers, than it is the privilege of the specialists. And just here let me add, there are many who call themselves "specialists" who have taken up their *specialty* without taking a regular course in the science of medicine, thus leaving out the real ground-work of their specialty. Such men should not bear the title of doctor. They are not prepared to do their work near as well as the general practitioner. Some of your readers may infer from what I have written that I mean to cry down the specialists. I simply desire to elevate the general practitioner and place him just where he rightly belongs, regardless of the claims of the specialist. It is true, we have some very worthy and distinguished specialists, and far be it from me to detract one iota from their escutcheons. All honor and praise to such men as Chisolm, Munde and McGuire, all of whom were once general practitioners, and well grounded in the science of medicine before they became specialists. We need more such liberal minded men in our professio n to absorb the many mushroom specialist who are constantly springing up over the country.—*Jour. A. M. A.*

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**Me and the Cat.**

RICHARD X—— is an incorrigible youngster of ten who has shown a tendency to lay the blame of his misdeeds on other shoulders. His favorite scapegoat was the family feline. A jar of sweets could not be opened, or a bit of gingerbread purloined, or a vase broken to atoms, without a lame excuse of Dick's, "I guess it was the cat," calling forth his mother's reproaches:

"Richard, you must not lay the blame on the cat of all the wickedness you are guilty of in this house."

Not long after one of these upbraidings, in Sunday-school, his teacher asked Richard the question, apropos of the devil's power on earth.

"Who is responsible for the wickedness of this world?"

It was with a mixture of a contrite spirit and the old habit that little Dick answered: "Well, I suppose that I'm partly to blame. But—but I think our cat has her paw in it."—From the "Editor's Drawer," in *Harper's Magazine* for February.

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*October 10, 1893.*

### OPERATION FOR APPENDICITIS.

DR. A. M. VANCE: This specimen is an appendix vermiformis removed this morning from a patient whom I saw for the first time just before the meeting of the Surgical Society last night, having been referred to me by Dr. Trunnell, who was called and made the diagnosis just before I saw the case. The man æt. twenty years, had been treated as I understand six days for typhoid fever. It was a very rapid case; there was a large mass in the right iliac fossa; patient having been taken suddenly sick a week ago, having suffered pain all the time; with loss of appetite, and nausea whenever he attempted to take food. McBurney's point was very well marked. There was no evidence of general peritonitis; there had been very little fever according to the history I was able to elicit from the family. His pulse was 90 and temperature 100 F. when he arrived at the Infirmary. I operated this morning evacuating probably 1½ pints of pus and along with it a number of fecal casts. I show you in this vial three which have been dried out. I found the appendix covered by very much inflamed and adherent omentum, the appendix being gangrenous as was also its mesentery, which was extensive. I removed the appendix with a large piece of omentum packed the cavity with gauze around a glass tube. The patient is doing well.

#### DISCUSSION

DR. W. H. WATHEN: When you opened the cavity and removed these structures did you expose the intestines freely?

DR. A. M. VANCE: No, I simply opened the abscess cavity. The peritoneal cavity was shut off completely by adhesions of the great omentum to the parietal peritoneum. I stripped up the appendix to its attachment to the cæcum and tied it off in the cavity of the abscess, did not enter the peritoneal cavity proper at all.

### DEATH RESULTINC FROM A VERY SMALL CALCULUS IN THE BLADDER.

No. 2.—A month or so ago I was called by Mr. Morris to see a child eighteen months old, with a history that three days before he had been called on account of obstruction in passage of the urine; he had endeavored to catheterize the patient, but the catheter would not go in; finally, however, he passed a solid sound and the bladder was emptied by the side of the sound. The next day when he visited the patient the bladder was again full. It was there he noticed that the scrotum had become tremendously distended and he thought the trouble might possibly be hydrocele. In consultation with some of his colleagues he tapped one side, but drew off nothing except a few drops of water. At the end of the third day I was called and told him that I could not understand what caused obstruction unless it was the impaction of a stone. I had a very small lithotomy staff with me which I introduced and at once touched a stone. The child was in a very extreme condition and was uremic. I took away the tremendously distended prepuce so as to get at the urethra better and made an incision in either side of the scrotum, the bladder having been emptied by the passage of the staff. (The child died of uremic poisoning twelve hours afterward). After the incisions were made in the scrotum it was emptied of the fluid by pressure. Dr. Baker made a post-mortem and found this little stone outside of the urethra in the scrotal tissue about the deeper portion of the urethra.

It is an interesting specimen and caused the death of the child.

### AN EPICYSTOMY.

DR. I. N. BLOOM: A young man then seventeen years of age, on the fourth of July, two years ago, while celebrating the day in a perfectly natural way without excesses of any kind, fell astradle a fence. After about two or three hours he passed blood from the urethra; this micturition of blood continued for two wesks, then ceased. At the end of that time he was attacked with all the signs and characteristic pains of ordinary cystitis, He consulted a physician, who made the diagnosis of cystitis and treated the patient for quite two years. During that time the bladder was washed out at least once a day. The patient grew worse and the washings was discontinued; he was better during the intervals and worse when treated.

When he came to me, in July, he was suffering from high fever—temperature 102° to 103° F., with an extremely rapid pulse. He was then nineteen years old. He had never had intercourse; never had venereal trouble of any kind and gave a clear history. I felt satisfied that the case was one of secondary cystitis, and that in any event an operation would be justifiable. I consulted with Dr. Griffiths, who fully concurred in my views The fever went down in ten or twelve days, but the pulse continued very rapid—110 to 120 to the minute. I sent him to the St. Joseph infirmary, where he was treated four

or five days to get him into good shape for the operation. There was no more fever than could be accounted for by severe cystitis. I had examined his urine, found specific gravity 1018; pus, not a very large amount; sufficient albumen to be accounted for by the pus only, and, after a hasty microscopical examination, nothing indicating further trouble.

On the fourteenth of August, assisted by Dr. W. O. Roberts, I performed the operation of epicystotomy in the usual way, i. e., with an air bag (I would have preferred a water bag, but there was none at hand) in the rectum and the bladder distended with ten ounces of water. The operation was concluded without any trouble, the peritoneum not being the least in the way, and I removed from the bladder a large phosphatic stone 1½ ounces.

The boy did very well for a week, except that at no time, during the week, did he have any appetite, and with difficulty could he be persuaded to drink two or three glasses of milk; all other food was absolutely abhorrent to him, and he was supported mainly on wine. The peculiar part of it was that alalthough the temperature never went above 100F., the pulse never varied from 110 to 115, and 118 to the minute. I packed the wound with idoform gauze; used no sutures. On the second day I took out the gauze. For the first week the urine was voided in part through the urethra, and in part through the wound; at the end of the week very little came through the wound. On the eight day there was a slight slough in the wound. Although I did not consider it sufficient to be of any importance, I called Dr. Robert's in consultation, and he agreed with me. Ten days passed in this condition, pulse, and temperature remaining as stated. His abdomen at at no time was tympanitic, he had no chill, and altogether the case was a very puzzling one. Then the temperature became subnormal, 97.5°F. in the morning, not going higher than 98° and sometimes not higher than 99°F. in the evening. This was the condition of affairs until the boy died on the fifteenth day after the operation. Toward the end of the last four or five days, he almost ceased passing any urine by the urethra, all of it coming out at the abdominal wound.

It is my opinion that this patient died of pyelitis.

### DISCUSSION.

DR. A. M. VANCE: Did the patient become comatose before death.

DR. I. N. BLOOM: No, I saw him in the morning before he died. Death occurring in the afternoon. He was perfectly conscious up to the time of his death. I will state that the stone removed from the bladder of this patient, and which I have exhibited here tonight, weighs 1½ ounces. I had no opportunity for a post mortem.

DR. J. M. MATHEWS: About what quanity of urine was secreted each day after the operation?

DR. I. N. BLOOM: The urine would soak through the bandages, and there really was no way of estimating the quantity.

DR. A. M. VANCE: It seems to me that if this patient had suffered from any active inflammatory trouble, there would have been some rise in temperature.

DR. I. N. BLOOM: The temperature was at one time 101° F, never going any higher. The pulse was always high, between 110 and 120, the first ten days, and for the last five days between 120 and 140. Lack of appetite was characteristic from the first.

DR. T. P. SATTERWHITE: Is not continuous high pulse always indicative of peritoneal trouble?

DR. I. N. BLOOM: You can have peritoneal trouble with low temperature and high pulse, but you would expect some tympanitic condition of the abdomen, which was entirely absent in this case.

DR. W. L. RODMAN (Visiting): I think Dr. Bloom's explanation of the case is the correct one, I do not believe the patient died of peritonitis. I do not think you would expect to have peritonitis as late as the fifteenth day after the operation. I have never heard of such a case, and believe that peritonitis is often clearly shut out. I think the patient died of pyelitis and suppression of urine.

DR. W. H. WATHEN: If this be true, why were not there some mental disturbance manifest in the case?

DR. W. L. RODAM: I have seen suppression of urine with no disturbances of the mental faculties at all until very shortly before the end. I have seen cases where there was no urine at all scarcely with the patient's mental faculties perfectly clear until a very few hours of the end—in strangulated hernia for instance.

DR. W. H. WATHEN: Was there any change immediately after the operation?

DR. I. N. BLOOM: The change in two days was quite marked; there was an improvement in the patient's condition, the fever was reduced, but the pulse remained very high.

DR. W. H. WATHEN: It is impossible that the immediate cause of death was pyelitis, but I cannot think that there was suppression of urine otherwise there would probably have been more mental disturbance. I am sure that peritonitis was not a factor, because there could not have been sufficient peritonitis to cause trouble without evidences of it—distension of the abdomen and other characteristic symptoms. Still there may have been septic infection after labor where there was no distension of the abdomen simply a general infection destroying the vital functions, such as there may possibly have been in the case under discussion.

DISCUSSION.

Of a paper read by Dr. I. N. Bloom,

"SOME POINTS ON CHANCROIDS"

DR. J. M. MATHEWS: I cannot conceive of a subject of more importance to any Medical Society than that of syphilis. It is of value to have such a learned syphilographer speak to us as has been the case to-night. There is no general practitioner of medicine, no surgeon and no specialist who does not meet with this disease in some form. It is a terror to the profession. Just as I was starting from my office to attend the meeting of this Society, one of our business men came to me and said he wanted to ask concerning his brothér-in-law, who happens to be a young man twenty four years of age now in a very responsible position in business. I had to say to him that I believed the gentleman in question was not only seriously affected, but that he conld never recover. My reason for saying this was that he has syphilis of the rectum. I am sorry the essaylist did not reach that point. and tell us how to best treat syphilis. But whatever the mode of treatment, or its application, I am at least forced to believe that when this terrible disease does effect the rectum, it is incurable. I scarcely wish to qualify that assertion. I know some men believe that when syphilitic ulceration exists in the rectum, by proper antisyphilitic medication it will disappear. I have taken the position that if the trouble is syphilitic and is attended by stricture, it is just as incurable as cancer. I have never seen an ulcerated syphilitic rectum cured. Therefore in my special line I regard it in the same light that we do cancer of the rectum an incurable affection; the only difference between the two being that syphilis takes a long time to kills cancer kill, more quickly. It is to the advantage of the patient to have the latter. This is a subject in which we are all interested; the specialist of whatever kind meets syphilis in his special line, and I hope the essayist will in closing the discussion tell us how to cure it, if syphilis is curable. I mean, of course, his general plan of treatment.

DR. W. L. RODMAN: I was not prepared to believe until this evening that syphilis was so much on the increase and chancroid on the decline; though in thinking over the subject it does occur to me that I have seen in recent years more cases of syphilis and fewer of chancroid.

As to the etiology of chancroid—I must confess that I have never seen my way clear to accept the new theory that chancroid is due to simple pyogenic micro-organisms; I am constrained to believe that there is something specific about the chancroidal virus. I know that this theory is gaining more or less acceptance by the profession, but it seems to me that there are strong reasons for adhering to the old doctrine that there is something specific about the virus of chancroids. There are certain features which are difficult of explanation in any other way. I admit that no special germ has ever been found, but that is hardly a potent argument against the fact that one may be present. I have never seen for instance enlarged glands coming on as a result of suppuration say in the axilla from an abscess of the arm or the pectoral wall. I do not think we can get inoculation from ordinary healthy pus. I believe that there must be something specific in the pus that comes from chancroids.

DR. A. M. VANCE: Of course a great many cases of the character under discussion come under my observation, but I have not kept a record sufficiently accurate to be able to give any data on the subject.

DR. GEO. W. GRIFFTHS: I have seen more cases of chancroid than I have of chancre in the last year.

DR. W. O. ROBERTS: I am convinced that chancre is more common than chancroid I think that a great many of the cases of so-called chancroid we see in the hospital and in the clinics are really chancre. We do not follow the cases up long enough to be able to say positively. I know that several times I have missed the diagnosis, and have been corrected by the appearance of secondary manifestations later. As you know secondary manifestations do not always come on in a certain stated time; it may be three weeks, three months or six months. Then again it may be so slight as to hardly attract attention.

In reference to the specific virus of chancroids: Like Dr. Rodman I believe that there is something else besides pyogenic micro-organisms.

DR. I. N. BLOOM: All those who claim to have found the pathogenic bacilli of chancroidal virus, have failed to find anything but pyogenic germs in pus from the body of the gland or in the bubo resulting from it. This is quite contrary to the rule, but it is a fact that each investigator—and there have been eight or ten—who claims to have found the specific bacillus of chancroid, makes the further statement that he has been unable to discover it in the bubo. Is it your belief that specific chancroid is the cause of a simple bubo, *i. e.*, not specific in nature? Or do you believe that if there is a bacillus that is not a pyogenic micro-organism which is the cause of chancroid, it also exists and has not been found in the bubo?

DR. W. L. RODMAN: Pus from a bubo is just as inocculable as pus from a primary lesion, and if there be a specific germ in a primary sore, then that germ should be found in pus from a bubo.

DR. I. N. BLOOM: Pus from acne will produce the same sort of a sore by inoculation.

It is claimed by some, for instance, that after a time the pyogenic micro-organisms disappear from repeated inoculations of the virus of chancroid, but that the sores can be perpetuated endlessly. This claim is disputed by those who have made experiments; what one side claims the other side attempts to disprove. The premises are not granted by both sides. I think the question is still subjudice.

DR. W. O. ROBERTS: Do you believe that the gonococcus is ever found except in gonorrhœal pus?

DR. I. N. BLOOM: It is declared that it is not found in gonorrhœal rheumatism, but to the best of my knowledge and belief it is found in suppurative bubo. Whether the gonococcus is the pathogenic germ of gonorrhœa, I am not prepared to state. I would like to have Dr. Frank express his opinion upon this subject.

DR. LOUIS FRANK (Visiting): It is conceded by all authorities, far as I have read, that the gonococcus is positively the cause of gonorrhœa. The gonococcus is not only found in gonorrhœal urethritis, but it is found in gonorrhœal buboes; also it has been discovered in the rectum of patients who had ulcerations and were supposed to have been infected by the gonorrhœal virus; my remembrance is that it has also been found in sores where infection has been supposed to have occurred, and in gonorrhœal joints. I have not seen anything to the contrary.

DR. A. M. VANCE: I believe that later investigators do not agree that the gonococcus causes the so-called gonorrhœal rheumatism. The idea prevailing is that gonorrhœal rheumatism is a joint disease the result of sepsis, just as in the fever following child birth we have a pyemic condition.

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Dr. Wathen reported

THREE SUCCESSFUL CASES OF VAGINAL HYSTERECTOMY.

(See page 201).

DISCUSSION.

DR. J. M. MATHEWS: I would like to ask Dr. Wathen the ages of the three patients referred to.

DR. W. H. WATHEN: The age of the first woman was forty-four years; the age of the second about forty-eight years; the age of the last thirty-three years. Dr. Louis Frank assisted me in these operations. Dr. Rodman was present at each of them, and Dr. Satterwhite was present at the last one.

DR. W. O. ROBERTS: Did you remove the appendages?

DR. W. H. WATHEN: I removed one of the appendages in the first case. In the second case I did not remove the appendages, because the broad ligaments were tense and the ovaries were held out so far they could not be included in the clamps and so it was not necessary to continue the operation further in order to remove them. In the last case I removed the ovary and tube from one side. The other was high up so I left it.

DR. W. O. ROBERTS: I would like to ask Dr. Wathen why he prefers vaginal to abdominal hysterectomy.

DR. W. H. WATHEN: Vaginal hysterectomy is much easier than abdominal hysterectomy and results have been far more favorable. In the practice of an expert operator who observes everything in the interest of the patient, the mortality should not exceed five to ten per cent. The operations for cancerous disease performed several years ago, show an immediate mortality of nearly twenty-five per cent, and the permanent results were not nearly so favorable as in the operations by the vaginal method. But this would be very much changed now; the mortality in abdominal hysterectomy would not be so great as formerly because we now cleanse the vagina and uterus and by curettage, remove all danger of sepsis from that source; we place the patient in the Trendelenberg position and can ligate the broad ligaments ovaries, etc, much better than we could previously. It is probable that the immediate mortality from abdominal hysterectomy would now be very low. I have a patient under observation upon whom I shall probably do an abdominal hysterectomy, Some six months ago I curetted her thoroughly and removed a great deal of cancerous tissue from the body of the uterus, the neck being apparently healthy, The tissue removed was examined microscopically by Dr. Frank, and I believe also by Dr. Vissman, and the trouble pronounced unquestionably carcinoma. The uterus was found to be twice its normal size, and the vagina very small, the patient being a maiden lady of fifty-two years, I requested that she report to me when there was a recurrence of the trouble. About three months after she returned home she married a "rich old widower," and has had no symptoms of cancer since, but she will have a recurrence of the growth, and if she returns to me I shall do an abdominal hysterectomy because the uterus cannot be removed through the vagina.

DR. A. M. VANCE: What do you think of the operation of scacral section?

DR. W. H. WATHEM; That operation has been made prominent by Dr. Montgomery, of Philadelphia. I have read everything he has written upon the subject and have talked with him about it. While he deserves praise for his courage in this work, I see no real necessity for the operation. I would much prefer, if the vagina is too small to remove the uterus through that channel, to preform an abdominal hysterectomy.

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*On Gout,* as Peripheral Neurosis. By Willoughby Frances Wade, Fellow of the Royal College of Physicians, etc.; Consulting Physician to the General Hospital, Birmingham. London, Simpkin, Marshall, Hamilton, Kent & Co. Limited. Birmingham, Cornish Brothers, New Street, 1893.

In this little book of fifty-nine pages, the author refers to the three theories current in regard to gout; namely, the humoral theory, the neural or nerve theory, and the neuro-humoral theory, and expresses the conviction that the latter accounts for more of the phenomena of this disease than any other. The frequency with which the joint of the great toe is attacked, as well as some other isolated facts, is cleverly explained, and the whole essay is an interesting addition to the literature of this important disease.

*Traite des Retrecissements de l'Urethre,* par le Dr. P.. Harmonic, etc., etc, with a preface by Prof. Tillaux and 107 cuts in the text. 625 pp., Octave Doin, publisher, Paris, 1893.

Among the functions which are absolutely necessary to the physicial health of man that of the kidneys and their appendages easily take a place in the front rank. Strictures of the urethra, in forming an obstacle to emission of the urine, are capable of producing a great amount of suffering and even death itself. Hence it is by no means astonishing that the attention of surgeons, of all times, has been directed towards the treatment of this serious conditon. An enormous number of works have been written on this subject, and, it is far from being exhausted. This publication, is, without doubt, the most important, and, at the same time the most complete, which has been offered to the medical profession on this subject. It is warmly recommended by the well-known Prof. Tillaux, of Paris, who has honored it with an extensive preface. The work is divided into three parts, the description of urethral strictures, their complications and treatment.

The first section, occupying one hundred and eighty-seven pages after a preliminary definition, goes deeply into the consideration of the etiology. Gonorrhœa is the most frequent cause on account of its chronicity favoring the formation of cicatricial tissue. Besides urethral gummata and congenital strictures, they are of either inflammatory, cicatricial or a mixed origin. The clinical course and symptoms, examination of the patient, measurements of the urethra and the requisite instruments and principles, the various varieties in man as well as in women, together with the pathology, a dignosis and prognosis are fully considered. The portion relating to the complications covers four hundred and three pages and deals very completely with all the details of our knowledge referring to them. The third section considers their treatment, it being quite exclusively and properly surgical. It fills one hundred and eighteen pages. It is a practical work and shows the results of careful study and experience. It may be recommended to those desiring a special work on this subject, for it neglects no detail but treats all fully.

*Etude Sur le Dermographieme ou Dermoneurose Toxivasomotrice,* par Toussant Barthelemy, Medecin nomme au concours de Saint-Lazare, etc. With seventeen cuts in the text. 287pp. Societe des Editions Scientifiques, 1893.

Under this title, dermographism, the writer has studied a condition in which the skin presents the peculiar power of retaining inscriptions written on the surface with any blunt instrument. This sensitiveness of the integument may be so great that various dermatoses, as for example infectious diseases, may be simulated and give rise to errors in diagnosis. It is a special state of the vasomotor nerves, in a specially susceptible nervous system, which is impressionable or impressed either by heredity or by acquirement, due to the influence of the toxic agent, acting on the vaso-motor nerves, either peripherally or centrally. He first studies and examines the influence of heredity, social conditions, etc., in its causation, its pathogeny, its relation to allied states as blushing, spontaneous ecchymoses, hemorrhages, etc. By means of electricity he had succeeded, with electric currents of high tension, in producing experimentally a state very closely resembling dermographism. Its diagnosis is quite easy, though it is freqgently passed over unperceived. It is only necessary to mark with any blunt instrument, the finger-nail, the end of a pen-holder, etc., on the skin of a susceptible subject, in order to observe the skin rise up in relief over the track of pressure and retain the impression more or less distinctly, for a longer or shorter time. It is a vaso-motor disturbance, without pruritus, sensation of heat, anesthesia or hyperesthesia, as in urticaria. Its practical importance may be at once seen, in that in certain forms, various cutaneous affections may be simulated. As remarked before, it is an associated symptom of the nervous diathesis and arthritism. The work is divided into two parts. In the first he considers fully the various details of our knowledge of this subject. The second contains the records of the cases which he has observed and collected, among which there is a large amount of interesting historical matter on the relation of this affection to witchcraft and trials for sorcery where the so-called impression of Satan's hand, etc., was remarked. It is a very interesting work on a subject quite unknown.

*Manley on Hernia.*

This work contains the fullest accounts of all the ancient and modern operations in hernia; besides, clearly sets forth those hygienic and palliative modes of treatment, by which many varieties of hernia may be cured in early life.

Price reduced from $3 to $2.00 (post free). Published by the Medical Press Co. Limited, 1725 Arch street, Philadelphia, Pa.

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*The Review of Reviews*

for February is strong in all of its departments. In the "Progress of the World" the important political, social and industrial events of the month are reviewed and their significance clearly and frankly set forth. This department alone contains fifty timely illustrations, chiefly portraits of well-known men and women. Among the portraits are those of President Dole and his cabinet and sketches, drawn from life, of Representatives William L. Wilson, of West Virginia; Chas. F. Crisp, of Georgia; Thomas B. Reed, of Maine; Benton McMillan, of Tennessee; Thomas L. Johnson, of Ohio, and Julius C. Burrows, of Michigan. Apropos of the opening of the Manchester Ship Canal, the editor discusses that and various other waterway projects which are being considered by European governments.

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*February "Cosmopolitan."*

The secret of the great success of *The Cosmopolitan* is not so hard to find, if one looks carefully over the number for February. A story by Valdes, the famous Spanish novelist, the first from his pen to appear in any American magazine, is begun in this number. Arthur Sherburne Hardy's story, "A Rejected Manuscript," is charmingly illustrated by L. Marold, who we believe makes his first appearance in the magazines on this side of the water. A profusely illustrated article on the designing and building of a war-ship appeals to the interest taken by all in the new navy, and a thrilling description of a naval combat under the significant title: "The Meloban and the Pentheroy" describes, after the manner of the Battle of Dorking, a possible sea-fight, the outcome of which is watched by the entire naval world. "Gliding Flight" is an interesting contribution to the problem of aerial navigation by one who has studied the fight of soaring birds in the East for twenty years. Elaine Goodale, who married a member of the Sioux nation, has some interesting information of Indian Wars and Warriors. T. C. Crawford, the Washington correspondent, gives the first half of a startling story, under the title of "The Disappearance Syndicate." The poetry in this number by Sir Edwin Arnold, Graham R. Tomson and William Young, is unsually good. The departments, "In the World of Art and Letters" and the "Progress of Science" continue to have as contributors men famous in both continents.

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*The February Number of Godey's Magazine*

appears in a new and most attractive cover, and with many innovations and improvements in the inside of the *Magazine*. In every respect this number is the most attractive ever issued by the Godey Publishing Company. It has a choice and varied contents, the opening article, "How to Make Money in Wall Street," being from the pen of Henry Clews. There are the opening chapters of a novel, "This Man and This Woman," by Margaret Lee, with illustrations by Paul Nimmo Moran; a short story, "The World's Gain," by Henry Milford Steele; "Superstitions of the English Miner," by S. P. Cadman; "Feroline," short story, by Lucy C. Lillie; "The Valley of Roses," by Prof. A. L. Rawson; "The Royalty of Hawaii," by Herbet Stanely Renton; "American Women in Mexico," by Marie Robinson Wright; "A Tragedy Pro-Tem," short story, by James Clarence Harvey; "A Begging Letter," a farce, by Anna Robeson Brown, with short sketches, numerous illustrations, and poems by Louise Chandler Moulton, Clinton Scollard, Richard Burton, Henry Tyrrell, Marie Frances Upton, A. L. Donaldson and others. Florence Hull conducts the Home Department, Stella G. Florence's name appears as fashion editor, and there is a new department for Our Boys which ought to attract universal attention.

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**Flint (A.) on Treatment of Fermentative Dyspepsia with Subgallate of Bismuth.**

Dr. Flint states that in nearly every case of functional dyspepsia under his observation within the last ten months he began treatmeant by giving five grains of bismuth subgallate, either before or after meals. In some cases it seems to act more favorably when given before meals, and in others its action is better if taken after eating. Salicin he has often found to prove satisfactory. The proportion of unsuccessful cases was about twenty-five per cent., but in some cases the effects of this remedy when given alone have been remarkable. The bismuth subgallate, however, is almost a specific in cases of purely functional dyspepsia with flatulence. He has used bismuth subgallate since December 8, 1892, and reports but two cases where no relief was noticed. Both of these cases were in hysterical women. He first used the remedy in a case of dyspepsia of eleven, years' standing with excellent results.

The following are a few of the cases of remarkably prompt and favorable action; A case of alcoholism of twenty years' standing, with habitual dyspepsia for the last five or six years; bismuth subgallate gave almost instant relief. The flatulence and distress disappeared in twenty-four hours, and did not return, except in a very mild degree, when they were usually relieved by a single dose. A case of dyspepsia of four's standing, with with a chronic diarrhœa, was entirely cured in five days by the use of subgallate of bismuth alone. In this case, the trouble returns every few weeks and is relieved by two or three doses. He prescribes it in the tablet form, each containing five grains.

During the treatment of the cases patients are simply directed to avoid excesses in food and drink, and to eat little or no pastry or sweets.—*N. Y. Med. Jour.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

## THE BUFFALO MEDICAL AND SURGICAL JOURNAL

for February.

An editorial on Symphyseotomy gives a short history of the operation, states that it has been employed during the past year by nearly every obstetric surgeon in the larger cities of America, and concludes; that while it cannot displace Cæsarean section in cases of extreme pelvic deformity, yet it may do so in cases with a useful diameter between six and seven and five-tenths centimeters.

The operation is described, and declared more easy, but probably not less dangerous, than Cæsarean section, and to be performed only by skilled surgeons. No reason, except easy performance, is advanced for preferring it to section.

A Letter from Mr. Lawson Tait criticises a paper by Dr. F. Byron Robinson, under the title

**What Kills After Laparotomy, Anæsthetic, Nephritis, or Infection'?**

Except for incisions in the flank the term laparotomy is objected to.

The author describes his discovery that ether stops, during its administration, the secretion of urine; while chloroform has not such action. Renal and pulmonary lesions, he says, leading to death, may be due to the use of ether.

Degenerative kidney changes are a frequent accompaniment of abdominal tumors of all kinds; but even when known to be present do not prevent his operating, but cause him to use chloroform. Cases are cited confirming his stand.

He does not think experiments on animals sufficient ground for treatment of human beings, and shows how the public sentiment, combined with the different inquest laws of England and Scotland, lead to the use of ether in the former and chloroform in the latter country.

He now uses, and so far with perfect satisfaction, a mixture of chloroform and ether, varying from one-third chloroform in the young to two-thirds for those forty years of age, or more. He calls this "ether mixture" and follows rigidly Simpson's directions for administering anæsthetics.

Dr. Marcell Hartwig read before the Buffalo Academy of Medicine a paper on

**Prostatic Disease With Special Reference to the Prostate of Old Age.**

He states that in spite of modern methods, operation for prostatic hypertrophy has resulted in very little benefit in most cases, and then, claiming little personal experience, gives a synopsis of the treatment of various authorities, and decides that so long as a man can completely empty the bladder by a catheter, operation is not called for; but as soon as he leaves some residual urine, an operation is necessary or cystitis, uræmia, and finally, death will result.

Supra-pubic cystotomy seems to be the choice of the author, but he is by no means enthusiastic in recommending it. The experiments of Dr. White are mentioned as proving the fact that atrophy of the prostate follows castration, or ligation of the vasa deferentia.

A very interesting discussion followed, in which most of the participants seemed to regard supra-pubic cystotomy advisable without delay, when cystitis threatened, or it became impossible to completely evacuate with a catheter.

Some of the speakers had operated successfully and a case was cited where a hard rubber tube was subsequently worn for several years, giving great comfort.

In regard to the opinion of Dr. White, doubt was expressed whether castration or ligation of the vasa deferentia would give relief to those elderly men to whom the testes were almost, or quite, inactive; as it was very improbable that any one would permit such interference at an early date, before the pain and obstruction became severe.

The prompt effect of a twenty per cent solution of antipyrin in stopping hemorrhage from the bladder was mentioned. Its use had been suggested by its known effect in epistaxis, etc.

The remaining paper, by Dr. W. A. Crockett, is entitled

**Observations on the Results of Removal of Diseased Uterine Appendages.**

Accompanying the paper is a table of thirty cases, showing the reason for operating and the condition before and after each operation.

The author does not claim to cure every case in the sense of completely rejuvenating her, and leaving her without ache or pain, and complains of those opposed to the operation denouncing it because this is not done. No other surgical procedure, he says, is subjected to such a test. His results have been good, though, and the symptoms complained of relieved.

The causes preventing perfect cure he classes under the following heads:

Ventral hernia, which is apt to follow in cases where a drainage tube is used.

Lack of skill and judgment on the part of the operator.

Neglect of treating all the disease. The author thinks endometritis exists in every case of salpingitis, and every uterus should be curetted before excising the tubes and ovaries. Every displaced uterus should be replaced.

The impossibility of leaving the pelvis in absolutely normal condition. Where raw surfaces are left, there will be some adhesions.

Affection of other organs, dependent or independent of disease of the pelvis. The ultimate results of this operation are influenced very largely by the effect of long standing tubal disease on other

organs, particularly the nervous system. When refractive troubles in the eye are corrected by glasses, the headache, due to them, does not instantly disappear, and a similar condition exists here, the focus of irritation is removed, but its effects pass away slowly.

Effect of long suffering and treatment on the patient's morale. The patient becomes morose and has a habit of magnifying every ache or slight pain; which makes her statements worthless.

Patient's subsequent occupation and condition of life: Many follow occupations which would be exhausting to a perfectly healthy person.

Besides having seen little good result from electricity, the author states that none of his patients could afford the tedious six months' or year's treatment which electricians require. The author sums his argument as follows:

Each case must be judged on its own merits and surrounding circumstances. There is no one form of treatment which will guarantee a cure.

Salpingo-oophorectomy stands on the same level as any other surgical procedure, and its results are influenced by a variety of elements which may play a part after any surgical method of treatment.

The results of salpingo-oophorectomy are sufficiently encouraging to justify its performance after milder methods have failed.

The most serious mistakes a physician can make are: (*a*) continuing local treatment after such a course has proven worthless; (*b*) making too positive assertions as to the favorable result of treatment.

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THE CHARLOTTE MEDICAL JOURMAL

for January. Dr. J. Wellington Byers contributes a paper on

**The Antisepeptic or Rational Treatment of Typhoid Fever,**

advocating the use of calomel and the cold bath in the disease. His plan is to administer at the beginning of the attack small doses, sixth of a grain, of saccharated calomel, combined with bi-carbonate of soda, every hour till the bowels have been freely evacuated. This is repeated every day, or every other day, during the first ten days' sickness, as the indications demand, unless diarrhœa supervenes. when the remedy is suspended for a time. The author states that it is exceptionally rare to have a diarrhœa at this stage of the disease when calomel is emproyed in this way. Under this treatment he finds that the functions of the stomach are more properly performed. The tongue is clean and moist, there is absence of tympany, the secretions are open with perfect glandular action—a series of circumstances in which it is quite impossible to have diarrhœa. The author states also that there is no danger of salivation from its use in this way. It does not produce hypercatharsis, or does it induce asthenic conditions, as is generally believed. To the contrary it is a gentle and true tonic, which promotes activity of the mucous membranes and glandular organs, hastens the illimination of morbid substances in the tissues and circulation, and through these influences brings about a high state of cell activity, and the vital resistance of the entire organism is augmented. In addition to those general physiological actions it possesses antiseptic properties of undoubted value. The author is quite certain that it will lessen and prevent a large proportion of the pyrexia which usually accompanies this disease when treated by methods which fail to recognize and modify the seat of and cause of the fever. In the author's cases, ranging in ages from six to sixty years, the fever rarely reached a maximum of 103°, and when it did, it was in every instance promptly controlled by the exhibition of the remedy. The author believes that by the use of calomel in this way we avoid stupor and delirium, which are largely attributable to toxæmia, lessen the liability to the presence and inroads of the pus-producing cocci in the later stages, prevent ulceration and hemorrhage, and remove one of the most potent sources of death.

Dr. E. C. Boyte reports a case of "Superfœtation." The patient was delivered of a healthy female child at term and with the placenta was expelled a fœtus of three or three and one-half months, contained in a separate sac, which at the placenta margin seemed to be attached to that of the fully developed child by a substance resembling the gelatine of Wharton. The placenta and fœtus were in a healthy condition, and the circulation was independent, there being no anastomosis between the vessels.

Dr. Archer Atkinson contributes a paper on "Fistula in Ano," advocating the use of the elastic ligature in the treatment.

John J. Caldwell contributes a Review of Recent Electro-Therapeutics and Electro-Surgery. [Judging from the tone of the paper, electricity is the cure for all diseases. The author speaks of a new instrument, which he names the phonoplaint and which, when applied to any part of the body, will instantly indicate the condition thereof by certain sounds or movements. The author does not describe this wonderful instrument and states that "so far we have not deemed it best to present an illustration of my phonoplaint instrument."—ED.]

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THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY.

for January. Dr. Howard A. Kelley in a paper on

**The Diagnosis of Pelvic Inflammatory Diseases,**

presents the following conclusions:

(1) The history of the patient, associated with pain in the ovarian regions produced by deep abdominal or vaginal palpation, cannot *per se* establish a diagnosis of pelvic inflammatory disease.

2. An attempt to make a diagnosis without directly palpating the pelvic organs is at best but more or less clever guess-work.

3. The diagnosis can be made with certainty when resisting masses are felt choking the posterior half of the pelvis at the sides and behind the uterus.

4. It is possible in this way sometimes to mistake a retroflexed fundus, an extra-uterine pregnancy or a myoma, for inflammatory disease. This error on the part of the general practitioner, however, is in the right direction, calling for a more exact investigation or consultation with a specialist, and is therefore not detrimental to the patient.

5. For a more delicate appreciation of the exact condition of the pelvic organs, and in many cases in order to make any diagnosis at all, a bimanual examination by rectum and abdomen under anæsthesia is necessary.

6. The writer's trimanual method of examination by rectum, vagina and abdomen, is the most accurate of all, serving to detect the slightest irregularities of the uterus and ovaries, as well as the most delicate adhesions.

Dr. William Goodwell contributes a paper on

**The Effect of Castration on Woman,**

in which he states that his experience would lead him to the conclusion that, in the majority of the women who have been castrated, the sexual impulse, soon abates in intensity, much sooner than after a natural menopause, and that in many cases it wholly disappears.

He also believes that the death-rate from chronic diseases of the appenadages is greatly overrated, so much so that, in his opinion, more deaths result from the operation of removing the tubes and ovaries, in the hands of even the most successful gynæcologists, than from the disease itself. In his experience, after the patient has safely passed through the acute stage of the inflammatory attack, her life is in very little danger.

The life of a woman with one damaged appendage is in greater danger than the life of a woman with both her appendages diseased on account of the liability of the old inflammation being relighted by parturition. The author believes that a surgical operation is not always necessary to cure the ill-health of a woman whose appendages are diseased, and he goes further and asserts that even cases with all the subjective and objective symptoms of ovarian or tubal abscess have been cured by him by means of massage, electricity, local applications and general tonics. In a very few of these cases conception occurres. When driven to operation, the author advocates removal of the diseased side only, unless the menopause has been established already, or unless a good reason obtains for hastening it on. Should both ovaries be intrinsically diseased and their tubes contain pus, he would always remove both uterine appendages in their totality no matter what the age of the patient might be. When the pus is limited to the tube he would leave the ovary after breaking up all adhesions, or, at any rate he would leave some of the ovarian stroma in order to avoid the sexual changes resulting from the enforced menopause. Should the uterine appendages be merely adherent, and not intrinsically diseased to any extent, he would, as a rule, during active menstrul life, release them, and, perhaps, extirpate the worse of the two, but not both of them.

In regard to the removal of the appendages for the cure of insanity and epilepsy, if the insanity is limited to periodical outbreaks, strictly ovarian in their character, and with the menstrual flux as a storm center; if the epilepticits are preceded by an ovarian aura—that is to say, if they pivot around the monthly period, and appear at no other time—the removal of the appendages, by suppressing a pernicious menstruation, usually will bring about a cure in either disease. But when these organs are extirpated merely as a panacea *per se* for these disorders, irrespective of their ovarian origin, the operation affords no relief. The author is inclined to advocate the castration of the insane of both sexes for the prevention of the spread of insanity.

Dr. A. W. Johnston disscuses the

**Aetiology of Dermoids of the Ovary and Testicle.**

The conclusion which he arrives at are: First, that embryology is the proper field in which to study dermoids, and it is in the formation of the ovum itself, and not during its stage and in the manufacture of the individual, that we must expect to find this fault. Second, that no practical use has yet been made of the well-known fact that up to a certain point we are all protozoa, just as well as in the later stages we become amphibians and such like. Third, that it is in the study of this protozoic age that we must expect to find the seeds which result in the formation of dermoids. Fourth, that the author's studies accentuate the fact that a human being in its development passes through all the stages of animal life, from the lowest to the very highest, and that a failure to pass from one stage to the next highest is sure to leave its imprint in the shape of a pathological condition.

Dr. George S. Peck contributes a paper on

**Extra-uterine Pregnancy,**

reporting five cases. One case is of interest on account of the division of the lumen of the fallopian tube into three, one of which ends in a cul de sac, the other two coalescing further on. The pregnancy, however, took did not take place in the closed part of the tube. All five cases recovered, with the exception of the fifth who was in collapse when operated upon and died on the table in spite of the use of large doses of digitalis, whiskey and strychnia. The paper is illustrated by photographs of the specimens removed.

Dr. L. J. Hammond also reports a case of "Extra-uterine Pregnancy at three months."

Dr. W. J. Hunter Emory reports a case of "Floating Kidney—Nephropexy." The sutures were removed on the sixth day. Union by first intention thoroughout. Temperature never rose to 100°. Some months have now elapsed since the operation, and the kidney remains *in stiu*, the patient wonderfully improved in general health and doing general housework.

This issue of the journal also includes an abstract of a paper by Dr. A. Margen Cartledge, entitled "Is Operation Demanded in All Cases of Appendicitis not barred by surg-

ical limitation should be operated upon. The best time, provided the symptoms are not too urgent, is after the bowels have been thoroughly moved.

In the Department of Pædiatry Dr. Merrill Ricketts discusses

**Excision of the hip-joint in Tubercular Disease.**

The author, in regard to the reason for entering the joint, gives the following: First, acute suppuration, bony or synovial, origin due to any cause. Second, acute tubercular suppuration. Third, arthritis, non-suppurative, but generally occasioning great pain, or deformities by other means. In number one and two resection is the vital indication. Number three not so important; let alone except to walk orthopædically. Do not remove the head for simply synovial fluid or marginal ostitis, or osteomyelitis of head of bone, but in cocco-femoral articulations, involved by suppurations, the head should be removed.

The remaining article in this issue, "Surgical Shock" by Dr. Charles P. Noble, has already been published in THE MEDICAL AND SURGICAL REPORTER for January 20th, 1884, page 80.

# PERISCOPE.

## MEDICINE.

### Brannan (J. W.) on Quinsy and its Treatment by Early Incision.

The author's studies tend to confirm a fact which has long been accepted by most laryngologists, viz., that the operation of opening a peritonsillar abscess is attended with no danger if properly performed. They also emphasize the necessity of early evacuation of pus, lest ulceration of an adjacent artery may take place. He offers the following conclusions:

1. In quinsy, the inflammatory process is usually situated without, and not within, the tonsil. 2. If pus forms it should be evacuated at the earliest possible moment. 3. Unless there are signs of pointing elsewhere, the incision should be made through the soft palate directly backward. 4. If the tension of the parts is very great, the incision is indicated, even though pus has not formed. 5. If ordinary surgical care is exercised, there is no danger of wounding the internal carotid artery. 6. In cases of deep-seated inflammation, in which the pus comes to the surface slowly, erosion of the arteries in the neighborhood may take place. In such cases, therefore, we must be ready to deal with arterial hemorrhage at the moment the abscess discharges into the pharynx — *Med. Record.*

### Morrison (F. H.) on a New Physical Sign for the Early Diagnosis of Croupous Pneumonia.

In several cases recently seen where the general symptoms of pneumonia were present, but none of the ordinary physical signs, I have discovered what I am venturing to describe as a new physical sign. On careful auscultation of the chest I have heard jerky expiration over a limited area, and on noting the position of this area have found developed in it subsequently the usual signs of pneumonia. This jerky expiration is the first physical sign developed, and can be heard soon, if not immediately after, the rigor, before dullness or crepitations appear. It is much more distinct in children, but I have also heard it in adults. The following cases sufficiently illustrate what I wish to point out, though I have notes of several others: 1. A girl, aged four years, was first seen by me about 9 P. M. on April 29th of this year. Her mother stated that she was seized with a shivering fit about 12.30 P. M. on the 28th, having been previously quite well. Her hands were cold and she was drowsy and thirsty. There was pain in the limbs in the afternoon and her breathing was short. She became delirious about 9 P. M. When seen by me on the following day her breathing was very rapid. She had a slight cough and a very quick pulse. The temperature was 104° F. Except that expiration all over the right base was markedly jerky, nothing abnormal was found in the chest. On the 30th her temperature was 102°. The physical signs were the same. On May 1st there were slight dullness on percussion and fine crepitation over the right base. The pneumonia ran a normal course and the patient made a good recovery. 2. A young man, aged twenty, was first seen by me on April 3d of this year. He complained of pain in the right side and shortness of breath. On April 1st he became very heated whilst playing at football, and during the following night he had a rigor. His respiration was rapid, the pulse was quick, and the temperature was 103.4°. Except for jerky expiration at the right base posteriorly there was nothing abnormal on examination of the chest. Pneumonia was diagnosed at the right base. This was subsequently verified by ordinary physical signs. The disease ran a typical course, although convalescence was somewhat prolonged—*Lond. Lancet.*

### The Biological Treatment of Enteric Fever.

Though the principle upon which is based the treatment of certain diseases by means of the products of the vital activity of animal or vegetable organisms may seem dubious;

though, as with tuberculin, the subsequent outcome may be very disappointing and different from what had been hoped; though the explanation of the action may be wanting; though the result may seem chimerical, sufficient data have now accumulated to encourage investigation in this new field of therapeutics and to bespeak for it scientific consideration. The sixteen cases or more of tetanus reported as cured by the tetanotoxin, the many cases of myxœdema (and from recent reports some cases of psoriasis) said to have been vastly improved or cured by treatment with some preparation of the thyroid gland, the experimental and clinical work of the Klemperers and others with pneumonia, the work of Haffkine and others with cholera —all these afford some evidence of the practical value of the method, and encourage the hope that the principle upon which it is based may be applicable to many other diseases than those already named. We have already on several occasions discussed this subject in these columns, and have no wish to enlarge upon it now.

It is our present purpose to call attention to the valuable and reliable work of Eugene Frænkel and Th. Rumpf (*Deutsche Medicinische Wochenschrift*, 1893, No. 41, pp. 985, 987), at the New General Hospital of Hamburg, in connection with the treatment of enteric fever by means of sterilized bacilli of enteric fever and pyocyaneus-bacilli respectively, the report of which is couched in language at once conservative and assuring. The mode of procedure and the results in the two sets of observations were so nearly identical that we can speak of both together. Bouillon prepared from the thymus gland of the calf was inoculated with organisms of an ordinary degree of virulence and placed for three days in a thermostat kept at a temperature between 96.8° and 98.6°, and then sterilized by boiling for about twenty minutes in a water-bath at a temperature of 145.4°. Of this solution about eight minims (0.5 c. c.) were injected into the gluteal region as soon as the diagnosis was made. No noteworthy change was observed to follow, and upon the following day about sixteen minims (1 c. c.) of the fluid were injected into the other gluteal region.

This second injection was usually followed by slight elevation of temperature, sometimes attended with chilliness or a chill. On the third and on the fourth day a notable decline of the temperature was observed, together with free but not depressing diaphoresis. If at the end of this time the temperature manifested a tendency to rise, another injection of a larger quantity (2 c. c.) of fluid was given, and in this manner the treatment was continued, the dose being progressively increased.

In addition to the influence upon the pyrexia, the flow of urine was notably increased, diarrhœa was favorably influenced, and the general condition was improved. The result was the better the earlier the case came under observation. Complications and death were not invariably averted, nor relapses prevented, but the course of the attack was in most cases favorably modified and its duration distinctly shortened.

The results, on the whole, were eminently satisfactory. Of the thirty cases treated by Rumpf with cultures of dead pyocyaneus-bacilli, there were but three deaths. Frænkel promises to give at another time a detailed report of the fifty-seven cases treated by him with cultures of dead bacilli of enteric fever. Surely we cannot ignore the value and the importance of these observations, and the hope is certainly justified and the results recorded may be confirmed and extended by those of other observers. — *The American Lancet.*

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### Diphtheria.

In *The New York Polychinc*, Dr. L. Emmett Holt writes substantially as follows on the subject of diphtheria:

In the treatment of diphtheria the first thing is isolation. The poison is given off particularly in the discharges from the nose and mouth, probably not from the breath. Handkerchiefs or towels should not be used for the nose, but absorbent cotten or bits of old muslin which can be burned immediately.

All the latest researches upon the subject of diphtheria point directly to the fact that the disease is first local, and afterwards constitutional. It is our duty then to attack the local disease on the tonsils energetically with the hope that the process may be arrested. Many plans have been suggested for this, such as Dr. Seibert's submembranous injections, the use of the galvano-cautery, and the local application of strong germicides, such as 1-250 bichloride, Monsel's solution, and hydrochloric acid. My own preference is for the last mentioned.

℞ Hydrochloric acid .....1 part
Glycerine.....2 parts

This is to be used as follows: A swab made by twisting absorbent cotten upon a splinter is saturated with the solution, but not so as to drip, and while the tongue is depressed, it is applied to the tonsils with a rotary motion. A second swab is to be used for the opposite side, and a fresh swab for each application, all being burned after using. This should be repeated in cases like the one before us once in four or six hours for the first day, afterwards once in six or eight hours for three or four days, while the disease tends to active spreading, and after that less frequently.

The advantages of the hydrochloric acid are that it is a powerful germicide, that it produces a good deal of disintegration of the membrane, that its effects are easily limited, and the sound parts are not unfavorably affected by it. We use the strong acid, and not the dilute form. When I began using it, I felt a little timid about using so strong a solution, having recently had a very extensive experience with it in a hospital epidemic, where during the past two months we have treated thirty-two cases. I believe we need have no hesitation in using so strong a germicide. A swab is always to be preferred to a brush for making such applications, since

with a brush the solution is likely to drip and injure adjacent parts.

In addition to these germicidal applications, and the earlier they are begun the more useful they are, the pharynx is to be kept clean by the hourly use of a gargle in children who are old enough to do this, or in younger infants by syringing the mouth, or swabbing with some weaker solution. For cleanliness we may use Dobell's solution, Seiler's solution, or bichloride 1-5000 containing ½ glycerine. These applications are not expected to do more than to keep the parts clean.

There is no call for nasal syringing in a case like the one before us. It is, however, to be begun in every case as soon as nasal discharge appears, whether there is visible membrane in the nostrils or not. This should be done with a small glass syringe, having a soft rubber tip, repeated every hour during the day, and every two hours during the night, without taking the child from his crib. Any of the three solutions mentioned above may be used for the nose. The addition of glycerine to the bichloride solution renders it less irritating.

What internal treatment shall we employ? None whatever excepting stimulants. We have no specifics for diphtheria, and after a through trial of most of the drugs recommended for use. I have abandoned them all, having become convinced that none of them have any special influence upon the course of the disease.

How soon shall stimulants be begun? This is a question which must be decided in each individual case. In some cases it must be begun on the first day; in others on the third day; in some not until the sixth day, and in some not at all. In diphtheria as in other diseases the best guide to the time for stimulation and to the amount of stimulants called for, is the patient's general condition and pulse. It is, I believe, a mistake to stimulate every case of diphtheria from the outset, in order to anticipate heart failure late in the disease. However plausible this may appear in theory, in practice I believe it to be very much inferior to the plan of withholding stimulants until they are indicated by the patient's pulse and the heart's action, when they should be pushed until the desired effect is produced.

For the swollen lymphatic glands no treatment is necessary unless they are very tender and painful, then use hot applications rather than cold. These glands rarely suppurate in diphtheria—never, I think, unless the process in the throat is one of a mixed infection.

There is one other means of treatment of which I wish to speak, although not called for in this case, and that is calomel fumigations in laryngeal diphtheria. This was first introduced by Corbin, of Brooklyn, and its very great value is now admitted by everyone in New York who has had opportunity to see them applied. Next to intubation I believe this to be the greatest advance in the treatment of diphtheria during recent years. Ten grains of calomel are vaporized over an alcohol lamp every two to four hours, the patient being kept in a close tent, made of sheets about his crib. This is to be begun as soon as laryngeal symptoms appear. In bad cases calomel fumigations may be used every hour. In the last epidemic to which I have referred three laryngeal cases, and two of them severe ones, were cured by this method without operation. In one of these I have reason to believe there was membrane in the trachea as well as in the larynx.

To summarize in a few words our treatment of diphtheria, the indications are:

(1) Germicidal treatment, preferably by the use of strong hydrochloric acid; used early to be effectual; especially valuable in cases beginning upon the tonsils.

(2) Local cleanliness by the free use of a weak antiseptic solution in the pharynx.

(3) Nasal syringing with the same solutions in every case where there is nasal discharge.

(4) Alcoholic stiumlants begun as soon as the first systemic effects of the poison are seen, and in very severe cases pushed to the point of tolerance.

(5) Calomel fumigations as soon as laryngeal symptoms appear.

(6) Intubation in laryngeal cases not relieved by fumigation.

## SURGERY.

### Operative Treatment of Peritoneal Tuberculosis.

The *Boston Medical Journal* says: The value of operation in the treatment of peritoneal tuberculosis in children has been much disputed and even yet is by no means generally allowed. The numerous cases benefited by laparotomy have been challenged as to correctness of diagnosis and the indications which were believed to predict a favorable result. The report of Conitzer* of seven cases operated upon for tuberculosis of the peritoneum throws some light upon the points in dispute.

The children varied from two and a quarter to nine years old. Four cases were of the exudative form in which there was a diffuse superficial inflammation of the peritoneum, with numerous very small tubercles upon the parietal and visceral membrane, and free serous fluid in the abdominal cavity. In all of these cases there was but slight disturbance of the general health. Some anorexia and heaviness and disinclination to move about were the chief symptoms. Some of the patients, too, had gray-colored stools, though not otherwise icteric.

The other three cases were of the dry adhesive form in which there was more general disturbance and often pain, and a considerable degree of matting together of the intestines and omentum.

The operation consisted only of an incision into the abdomen, and, after allowing the free fluid to escape, closing up of the wound. No washing or manipulation of the cavity was done in any case.

**Deutsche Med. Wochenschrift*, No. 29, 1893.

The four exudative cases all made a lasting recovery. In each, microscopic examination of the tissue showed characteristic tubercular structure, giant cells and in two cases the presence of bacilli. The three other cases all showed caseous tubercular nodules with bacilli. One case recovered from the operation and after four and a half months was still relieved from much of the pain and discomfort, though not at all well. The other two cases died with little or no relief.

After discussing these cases in detail he draws the following conclusions:

1. Peritoneal tuberculosis is spontaneously curable; the dry form in very few, the exudative form in a very large number of cases.

2. All forms may be cured or at least relieved by laparotomy, even when other treatment, including puncture, has failed.

3. The results of the operation depend upon (*a*) the form of the disease, the best results being obtained in the cases of effusion; (*b*) the duration of the illness; (*c*) eventual complications.

4. The operation is contra-indicated in advanced diseases or those with marked tuberculosis of other organs.

5. No explanation can be given of the reason or manner of the curative effect.

## NEWS AND MISCELLANY.

### George W. Childs.

No private citizen of this world has been more widely known or more highly appreciated among all classes and conditions of men than George W. Childs Philadelphia sat in sorrow nearest his bier, but all our great cities, the country at large and the world feel his loss. Everywhere the press and pulpit emulate each other in sorrowful, yet grateful tribute to his memory.

The public is familiar with the brief record of his exodus. January 18th, he suffered from an attack of vertigo, which was almost immediately followed by paralysis. The tenderest affection and the best medical skill watched over his prostrate form and did all that both could suggest for his recovery, and the intervention of Infinite love and power was invoked in churches of all faiths, Jewish and Christian, Catholic and Protestant. But the course of nature and the Supreme will disposed otherwise. He passed away in the early morning of February 3d, and his remains were laid to rest beside those of his friend, Anthony J. Drexel, who preceded him by just eight months.

A facile pen, that of the Rev. George Dana Boardman, briefly sketches his character and career thus:

"Exemplary in life, high in ideal, steadfast in pursuit, conscientious in method, successful in accomplishment, just in dealings, truthful in engagements, charitable in judgments, strong in convictions, courageous in expression, gentle in manner, chivalric in journalism, enthusiastic in friendship, public-spirited in citizenship, boundless in charities, cosmopolitan in range, contemporaneous in gifts, architectural in career—in brief, Christian in character,—himself is his own best monument; his tributes to the great and his gifts to the poor being his own memorial windows.

### The Anti-Dispensary Party win the Day in New York.

Monday night the 15th ult., the most exciting election ever held by the New York County Medical Association was witnessed.

There were three candidates in the field running for president; and singular to say, they were all objectionable, though in varying degrees.

Dr. McLeod's candidacy was distasteful because he had been president three successive years; and, it was righteously felt that it was time for him "to step down and out," and make room for some ambitious aspirant from the younger crop.

Dr. Tucker Harrison, another candidate, though, like Dr. McLeod, admired and respected by all the members, yet had been president in the near past, and it was thought best not to further encourage him to seek presidential honors.

Those two honored veterans were confronted by a young man quite unknown in New York, Dr. Ferdinand Valentine, who was a member of the association but two years, but he proved that he was not wanting in fighting metal, and gave his opponents all they could do to prevent themselves from total annihilation.

On the night of the election the Valentine faction, which came in great force, and moved compactly, had hustling about the city, in every direction, while the rain fell in torrents, several coaches and cabs, to bring in the lame, the aged and the invalid.

The McLeod columns well compared with the magnitude and solidity of the Valentine forces. Rumor was now scattered, that Valentine had been a homeopathic physician; that he was yet an "unrepentant sinner;" that he and his faction only wanted to make the association an annex to another polyclinic, which New York is threatened with; that they were the same gang of specialists that brought disaster, disunion and ruin into the ranks of New York physicians ten years ago.

This item of news, which, however, contained more truth than poetry, produced a smiting effect among those who had come to rush on the young candidate.

Now that they were not to be worsted, they resorted to new tactics, and charged Dr. McLeod's manager, the candidate for vice president—Dr. A. D. Ruggles—with treachery and treason. A motion to put him on the rack was pressed by Dr. W. R. Pryor; but the president prudently choked him off, on a rule of order, and the balloting went on.

It was nearly midnight when the polls closed. On the first ballot McLeod, closely pressed by Valentine, came out first. Harrison was only third, though the Southern vote was thrown almost for him.

Now, as no candidate had a majority, a second ballott was cast, when the Harrison men, almost in a body, went over to McLeod, when he secured a majority; though, to the last closely forced by Valentine.—*Times and Register.*

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## ORIGINAL ARTICLES.

### A FEW CONSIDERATIONS ON THE SUBJECT OF CHOREA.

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We, who are prone to boast so much of the progress of modern medical science, were, no doubt, a little chagrined upon finding that he of the polished stone age, centuries before the building of the great pyramids, frequently and with success practiced trephining of the skull. In the light of this fact, no subject should be so time-worn or overburdened with literature, as to be of no interest to us in modern methods of medical investigation.

Our eagerness for prophylaxis, more rapid cures and better diagnosis, induces us to classify and generalize the great mass of written matter upon so common a subject as *chorea*. As Americans it may especially concern us to discuss a disease so sympathetic with our manners of living. The great tension under which our people are laboring industrially, politically and socially, is stamping them as the thin-blooded, restless, nervous American. One erudite penman has even accused us of creating a new disease—neurasthenia.

Closely associated to this is chorea, which is yet generally classed with the fast diminishing list of functional diseases. The symptoms of this disease scarcely need mentioning. It is the therapeutics, and more especially the etiology of the affection, that occupy the mind of the profession to-day, and upon these points there are yet wide differences of opinion. More than a score of causes of the disease are brought forward and defended by men in different parts of the world. Koch thinks it is not a neurosis, but due to a specific virus of an infectious nature. Last year a prominent Frenchman associated the staphylococcus aureus and albus with chorea in the relation of cause and effect. It, probably, was only a coincidence. Good men yet consider the cause as emboli in the cerebral arteries. Lyman, of our own society, classifies the affection under functional diseases of the brain, and states, no doubt truthfully, that it is purely a functional disease. I ascertained by writing to about thirty, that the physicians of our own state generally think of the disease as a neurosis, yet a few did not commit themselves on the subject. Though looking upon it as a neurosis, nearly all of them incidentally mention rheumatism as a possible cause.

Though the association of chorea and rheumatism was first recognized many years ago, an absolute relation of cause and effect has never been established. Lewis of Philadelphia, in a paper read before the Association of American Physicians, held in Washington last May, spoke of the interdependence of chorea and rheumatism, which was commented upon by Mitchell, Jacobi, Lyman and others. The assertion that the virus of chorea and rheumatism is identical will, no doubt, be influenced by the fact that curative remedies of the former disease often have no effect whatever upon the latter.

The literature of the last few years is very well agreed on some points connected with the disease, viz:

(1.) That females are more liable to the disease in the proportion of two to one.

(2.) The negro is not quite, but largely exempt from the disease.

(3.) Relapses occur in about forty-five per cent. of cases.

(4.) The disease shows a predilection for certain months of the year in the United States. This, however, is denied by Gowers, as the case in England.

(5.) No case is exempt; but from five years to puberty it is most common.

(6.) The mental faculties in most cases are considerably impaired.

(7.) The temperature of the body is unchanged.

(8.) It may affect only one side of the body, most frequently the left side.

(9.) There may be an hereditary predisposition to the disease, in which case it is incurable.

One of the points on which there is a difference of opinion is the electric excitability of the nerves. In two text-books, issued within the last year and-a-half, in this country, there are opposite statements upon this point. This, at first, may seem unimportant in studying the etiology of the disease, but when we remember the great similarity between electric and nerve forces—indeed, some believe them identical—the electric reaction of the nerves is by no means to be overlooked. That the organized body with its chemical changes is a great battery which creates and discharges nerve force is almost a self-evident proof.

In the electric paraphernalia of our offices, we must thoroughly understand the electro-motive force, intensity and constancy of our current, and the resistance which it encounters. These are facts we so seldom heed in the study of nervous diseases. In our materialistic age we rush madly on to the fray with those powerful weapons, scalpel, the test tube and microscope, forgetting that the very science we are creating is but the production of a higher science, that of the mental and vital operations, which are so intimately associated with tissue metamorphosis that without their relation we have no life. The mind and body have been evolved together, and should be a mutual fit.

The physical environments and mental facts cannot properly be studied apart from one another. To understand the nerve as a recipient of centrifugal impressions and as a conductor of force; and to understand the impression itself, is of the utmost importance in the study of such a disease as chorea. That the disease is often due to an intoxication of the centers of co-ordination seems probable from the many diverse signs we meet; yet the co-ordinate center need not necessarily be the affected area. Is it not possible that the conductivity of the axis cylinder is diminished or that the insulation has undergone a chemical change, which interferes with the transmission of the motor impulse? Chlorosis is so common in chorea as to suggest that the whole nervous system lacks some important element, probably oxygen.

The derangement is not necessarily in the brain, as a division of the cord is not followed by a cessation of bodily contortions. The fibres of the peripheral nerve trunks are liable to degenerations independent of lesions of the cerebro-spinal axis; and these changes may exist in chorea, thus interfering with force discharge and transmission; giving an uneven current, such as we have in a defective Faradic machine.

Thus the relations of the mental and motor energies are broken. They no longer go hand in hand; the motor units being irregularly discharged or transmitted in spite of the mental rheostat.

The molecular waves of force have no controlling influence, and, if they coincide, the intensity of their effect is increased; but if they stumble one over another, self-neutralization and inhibition take place, all objectively manifested in the abnormal rhythm of muscular action.

Chorea from fright is, perhaps, best explained in this manner, the great mental shock replacing for a time, or interfering with the rheostatic action of the mind. This irregular discharge need not depend on macro- or microscopical lesions. The changes, probably, are as wholly beyond detection as they are in neurasthenia. Just why some metals are better conductors of electricity than others is not fully known; no more do we know why one person is of a neurotic and another of a phlegmatic temperament, unless that subtle relation of mind and matter, that current controller of the human body is different in the two individuals in the chemical part of its constitution.

A disease dependent upon such a derangement would certainly be deemed a functional one.

A case of chorea with one peculiar feature came under my observation within the year. It was a strong, unmarried lady of twenty years. The exciting cause seemed to be grief. The muscular spasms came at regular intervals, about four per minute, and affected nearly all of the voluntary muscles of the body. As regular as clock-work, a violent muscular spasm, of only an instant's duration, shot through the body. The reflexes were normal and the patient felt perfectly well otherwise. There was an hereditary taint, a cousin or two having suffered from incurable chorea. To me the peculiar feature was, that by firm pressure on the first dorsal nerve of the right side, where the nerve passes over the spine of the scapula, the spasm could for a time be wholly surpressed, and at all times be greatly ameliorated. I discovered this only by accident. No anatomical changes could be seen at this point. Under heavy doses of antipyrin, recovery took place in about one week. Will some one explain why pressure on the point indicated above arrested the spasms, or whether I was mistaken in my diagnosis?

Sinkler gives a very interesting paper in the *Medical Record*, on hereditary or Huntington's chorea, in which he reports and re-reports a number of cases, carefully showing the hereditary tendency of the disease. He admits the pathology to be still unknown, but thinks it probably due to developmental defects. He calls attention to the fact that mental deterioration occurs in most cases, many of them landing in the insane asylum. He concludes that there are two varieties of this form of the disease, the division depending upon the time of mental degradation.

Many other papers, meritorious and common place, have been written during the year on chorea, offering nothing especially new on the subject.

Although chorea tends toward a spontaneous recovery, many cases are troublesome and even incurable, hence demand the best skill and care of every conscientious practitioner. The treatment of the disease in the last three or four years has undergone a considerable variation. Starr says the neurotic element, perhaps, is the one requiring attention. All peripheral irritations, such as intestinal worms, undue excitement, etc., must be removed.

The condition of the blood is one of the prime factors in the treatment of chorea, hence the universal use of iron and arsenic. While these are, perhaps, our most valuable remedies, arsenic is not an ideal one. But a short time ago, *The Lancet* reported a frightful case of pigmentation of the skin and paralysis, from the administration of the drug in chorea.

However wonderful the results of this remedy alone, we will hardly assume its power to remove cerebral emboli, neutralizing the rheumatic virus or changing the specific gravity of the optic thalamus, all accidental conditions that have been thought causative in chorea.

Antipyrin is rapidly coming to the front as a very valuable drug in chorea. The French are using it extensively and give very gratifying reports as to its efficacy.

Personally, in a few cases I have found it very efficient, even with its doubtful action upon the red blood corpuscles.

It is used in doses of from fifteen to sixty grains per day, associated with the same amount of sodium bicarbonate.

It often gives very rapid results. See recommends a combination of antipyrin and arsenic.

Electricity is recommended by a few, but the great majority of clinicians find it of little or no value. In rheumatic subjects the salicylates, or oil of wintergreen, should always be combined with the other remedies. It is very interesting to note that hypnotism or commanding the patient to remain quiet has been successful in treating chorea, within the past year. What a wide range for speculation this fact gives to the deductive mind. Is it not an excellent illustration of the possibility that the choreic movements are a direct outcome of those delicate, subtle changes, of which we know so little, under the direct control of the will?

Luys claims to cure these by means of revolving mirrors, which exert an influence only through the channels of the mind. He also claims that these cases are the most common ones we meet. It is not generally known—at least not practiced—that prolonged sleep in cases of chorea gives the happiest of results. Joffray recommends for the induction of sleep in these cases, chloral hydrate.

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THE Philadelphia Board of Health has refused to declare consumption a contagious disease.—*Pub. Opinion.*

# COMMUNICATIONS.

## THE DANGERS OF INFECTION BY PERSONAL CONTACT WITH DISEASES NOT REGARDED AS ACTIVELY CONTAGIOUS OR INFECTIOUS.

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[ABSTRACT.]

As no pretense will be made for any claim to priority for the subject of the remarks I have to make, I shall offer no apology for bringing to your notice a few of the facts on "the dangers of infection by personal contact with diseases not regarded as actively contagious or infectious." Nevertheless, I cannot hope to escape criticism at first sight by those who may believe that the discussion of this subject is untimely, in that special reference will be made to the double occupancy of beds which has been the rule observed by our ancestors from time immemorial, and it may be thought good enough for us now.

I am not unprepared to hear any reasonable amount of criticism, and I shall take refuge against it in the light of an advanced state of observation, which has given us more accurate knowledge and has replaced sophism by logical conclusions which physiological facts have shown to be more in accord with the laws of self preservation.

For many years there have been certain diseases recognized as not contagious or infectious, and yet persons who were known to be in good health before coming in contact with those afflicted by them, often became their victims. The *materies morbi*, which were at work causing many diseases, were accounted for hypothetically only, until Koch announced his discovery of the germ of consumption. Then it was that important light was thrown upon the spread of diseases which had hitherto been shrouded in mystery. Since Koch's important discovery of the tubercle bacillus, the science of mycology has received new impetus, and it is making rapid progress in the search for truths.

The danger of certain insidious diseases being transmitted by contagion or infection, before Koch's discovery was too little regarded by physicians. Now the importance of prevention is being fully appreciated, and it is receiving careful consideration at the hands of physicians and others whose duty it is to protect the health of those whose lives are entrusted to them.

Another important and more recent discovery has been found in the fact that there are certain disease germs which do not live in the normal air, and others that do live and thrive in it. Whether or not this peculiarity applies to any of the germs found in the diseases of the air passages, I have seen no mention made of it.

Now, let us consider the character of the excretions and exhalations which are present in every person in a state of health, and we find certain poisonous ingredients which render their immediate atmosphere impure. When these poisonous products are inhaled, they tend to weaken vitality and render the recipient more susceptible to the action of disease germs, while had these products been first subjected to the free air, their properties would have been changed and made inert.

In those suffering from disease, more poisonous products are present in their immediate surroundings, and in addition there are disease germs awaiting a suitable soil in which to grow and multiply.

There are many diseases of the air passages, indeed nearly all of those affecting the mucous membranes, that are now recognized as contagious or infectious, as well as the more insidious disorders which affect the lungs. Contact with these diseases render the subjects more liable to be infected by them. Children sleeping together in the same bed often convey the seeds of disease to each other through the respired air, which a distance of a few feet from each other might have prevented.

Imagine, by way of illustration, two persons occupying the same bed, one of which is sick and the other is well; the well one is inhaling the breath as it leaves the nostrils of the sick, warm and laden

with its millions of disease germs, and it will be readily understood how even insidious diseases not actively contagious or infectious may be transmitted to others. There are few physicians who have not been brought face to face with the sad scene of a house deprived of its most useful member for the want of precaution against those insidious germs which were conveyed from the lips or in the respired air from the lungs of a bedfellow who was the victim of consumption. It is, therefore, no longer any surprise to find that the husband or wife has become the subject of consumption after sleeping in the bed together, one of which being a victim to that insidious malady which knows no foe.

The remedy of this evil suggests itself, and it has already received some recognition abroad. Do away with the use of double beds, and replace them by single ones furnished with separate clothing. The same room may be occupied by the husband and wife, and the beds may be placed near enough to each other for companionship. This arrangement of the beds will cause the poisonous products of the exhalation of persons to become diluted and changed by the air, and rendered less injurious to health when again inhaled. The advantages to be derived from the use of single beds will become apparent for reasons other than for the prevention of the disease. The arrangement will, in most cases, tend to preserve the sense of delicacy which closer contact sometimes dulls. Again, when persons are fatigued from overwork or mental worry which give rise to insomnia, and cause them to become restless and roll about, or, when necessity compels them to leave the bed, the companion will not be awakened or otherwise disturbed. There are many other disagreeable features which annoy sensitive and wakeful persons, who occupy together double beds, such as heavy breathing, snoring, and other strange respiratory sounds, which distance would render much more endurable. Late or irregular hours on the part of a companion for retiring, often awaken the sleeper and his sleep is over for that night.

Many other illustrations might be given to show the injurious effect of persons sleeping together in double beds.

We live in an age of reason and observation, and as guardians of the public health, true to our trusts, it is our duty to consider matters of such vital importance as I have referred to in this short essay.

## PROCIDENTIA UTERI.*

CHARLES P. NOBLE, M. D., PHILADELPHIA.

The condition of procidentia uteri is of importance to the practitioner because of the frequency with which it exists, and because of its curability when properly treated. Without proper treatment it becomes progressively worse, until finally, in some cases, such changes ensue in the posterior vaginal wall and pelvic floor that its curability is questionable. In order to appreciate the treatment of procidentia it is necessary to refer to the factors engaged in maintaining the pelvic organs in their normal relations, and also to the causes which tend to produce their downward displacement, and especially to the displacement of the uterus. The tendency is strong to consider the uterus separate and apart from the other pelvic organs, especially in relation to the causes of its displacement. This tendency is unphilosophical and results in confusion and in erroneous inferences. In general, the same factors preserve all of the pelvic organs in their normal relations, and the same factors are at work in the displacement of each and all of these viscera. The influence of atmospheric pressure in maintaining the pelvic viscera in their normal relations is frequently overlooked. The peritoneal cavity is a shut sac immediately in relation with the thoracic cavity, being separated therefrom by the diaphragm. As under normal conditions the urethra, vagina and rectum are closed canals, impervious to air, it follows that atmospheric pressure has a very positive effect in maintaining the pelvic viscera at a certain level. This level is fairly constant, as the capacity of the thorax (which has a free communication with the exter-

* Read before the Obstetrical Society of Philadelphia, January 4, 1894.

nal air) is fairly constant. This influence of atmospheric pressure has been treated of by writers, especially by Thomas, under the heading of "The Retentive Power of the Abdomen." Atmospheric pressure is the constant factor giving the abdomen retentive power. Variations in the tonicity of the abdominal muscles interfere with this function; and when the abdominal walls become very lax from over-distention, or from atrophic changes, this factor in maintaining the normal status of the pelvic viscera becomes largely inoperative.

Habits of dress also modify the influence of the intra-abdominal pressure in maintaining the pelvic viscera in position. The use of tight corsets, by restricting the excursions of the diaphragm, tends to prevent the ascent of the pelvic viscera which takes place normally with each expiration. Also, by displacing the abdominal viscera downward and forcing the bowels down upon the pelvic organs, tight lacing acts by driving downward the pelvic contents. Tight lacing kept up for a long period of time, acts further by inducing an atonic condition of the muscles of the trunk, thereby interfering with the normal intra-abdominal pressure, and with the so-called retentive power of the abdomen.

Another factor which is not much dwelt upon is the adipose tissue which is present in the pelvis. When a woman becomes rather suddenlie and markedly emaciated, the loss of adipose tissue in the pelvis favors the displacement of the pelvic viscera. During and after the time of the menopause, when the fatty tissues about the genitalia very generally undergo absorption, displacement of the pelvic viscera often occurs. Prior to this time, in many cases, although various injuries which favor displacement may have been sustained, yet, owing to the presence of the fatty tissue, displacement does not result. In these cases, after the atrophy of the fatty tissues occurs, prolapse of the pelvic viscera takes place.

Other factors, not directly connected with the pelvic structures themselves, which must be considered are certain habits of patients. Too laborious work favors displacement of the pelvic organs, especially when their proper supports are for any reason weakened. As a rule, those who are called upon to do laborious work have vigorous muscular systems, and with intact pelvic organs no harmful consequences ensue. Such consequences are most apt to ensue when a feeble woman is called upon to do extremely heavy work, or when such work is performed by one who has suffered injury to the pelvic supports.

Constipation favors prolapse of the pelvic viscera for very much the same reason as does too laborious work—the straining at stool accomplishing the same result as the too laborious work. Constipation acts also by favoring pelvic congestion, which, no matter how induced, always favors displacement of the viscera by inducing laxity of the tissues.

These general considerations are of importance, not only as permitting the proper appreciation of the causes which underly displacement of the pelvic viscera, but also for the very great assistance in the curative treatment of these disorders which a proper appreciation of the above facts afford.

More important, however, than the forgoing are the proper supports of the pelvic organs themselves. In women, as in men, the entire pelvic contents are supported by the action of the levator ani muscles, the pelvic fasciæ, the sacro-sciatic ligaments and the pelvic connective tissues. It is true that the peritoneum and the connective tissue which lies under it affords some additional support from above. The bladder, the womb and its appendages, the vagina and the rectum, and the super-imposed, small intestines are all supported by the structures referred to. They make up the pelvic floor, and upon their integrity the normal position of the pelvic viscera depends. The connecting tissue of the peritoneum about the bladder and also about the rectum and the other organs has a minor influence in fixing within certain limits these organs. The uterus, more especially, receives other support than that of the pelvic floor—the utero-sacral, the broad and the round ligaments affording a certain amount of support to this organ. The careful study of the whole subject, however, is convincing that these ligaments, and the retentive power of the abdomen, brought about by the atmospheric pressure, are of importance, rather as maintaining the uterus in its normal position of anteflexion than in keeping it at a certain plane in the pelvis. Undoubtedly, these factors have a certain influence in preventing downward displacement of the uterus, but all combined

they are not of so much importance as is the normal pelvic floor.

The principal support which maintains the pelvic viscera in their normal relations is the pelvic floor, the most important structures in which are the levator ani muscles and the pelvic fasciæ. Upon the integrity of these structures the support of the pelvic viscera depends. When these structures no longer perform their normal functions, either because of atrophy or because of laceration of their tissues, downward displacement of the pelvic viscera is favored. This point cannot be too strongly insisted upon; nor can it be made too clear that these are the structures of importance in giving support to the rectum, vagina, bladder and uterus, rather than an imaginary structure formerly known as the perineal body.

The old theory that the perineal body was the prime factor in pelvic support must be definitely abandoned, because it is based in error. There is no such structure as the perineal body. The tissues between the lower end of the vagina and the rectum are certain slips of the levator ani muscles, the transversus perinei muscles, the deep and superficial fasciæ, connective tissue, blood-vessels and nerves, and the bulbo-cavernosus muscle. The ends of these slips of muscle unite in the median line, forming a somewhat tendinous union. The amount of tissue between the rectum and vagina is very much overestimated. Any one can demonstrate that this septum is scarcely more than a third of an inch in thickness if he will examine a nulliparous woman, placing the thumb in the vagina and the forefinger in the rectum. Such an examination will dispel from his mind any idea which he may have had that there is a large wedge-shaped mass of tissue situated between these two canals, which, in virtue of its size and shape, holds up the pelvic organs.

Women having the greatest amount of tissue between the anus and posterior commissure of the vulva, have really the least support for their pelvic organs. This fact, so directly at variance with the ancient teaching upon this subject, is easily explained. When the levator ani muscle, or a part of it, has been torn through, the pelvic floor drops down, and if the skin over the perineum has not been ruptured it stretches out. The anus drops down toward the feet and back toward the coccyx, so that the skin between the anus and the vulva is put upon the stretch. These facts are easily capable of demonstration, and any one who doubts them can easily satisfy himself of their correctness. They show also that visual inspection of the perineal region is insufficient to test its integrity. Cases which have appeared to receive no injury, may have severe lacerations within the vulva; and other cases which appear to have been badly torn because of the involvement of the skin over the perineum, may, in reality, have escaped without injury to the deeper and important structures of the pelvic floor. The examination, to be complete, must include palpation of the levator muscles to test their powers of resistance when drawn upon by the palpating fingers.

The physiology of the support of the pelvic viscera appears to be as follows: The rectum and vagina receive direct support from the levator muscles. Their orifices are kept closed partly by the action of these muscles, and partly by the sphincter ani and bulbo cavernosis muscles. The anterior wall of the vagina and the bladder are supported upon the posterior wall of the vagina; and the uterus and its appendages are supported upon these structures. The connective tissue attachments of the organs named, of course, are of service in limiting their mobility; and, in addition, the proper supports of the uterus are of much importance.

When all of the factors concerned in maintaining the pelvic organs in their proper relations are normal, these organs are retained in their proper positions. Their downward displacement is due either to increased pressure from above, or to diminished support from below, or to both. The influence of heavy lifting, of tight lacing, and of constipation, and of emaciation, in favoring displacement, have been considered. Two other causes remain, one is retro-displacement of the uterus, and the other is increase in the size and weight of the uterus. The influence of the second cause in favoring downward displacement is so clear that it is unnecessary to enlarge upon it. The influence of retro-displacement in favoring descent of the uterus is equally clear, if the anatomical and physical relations of the pelvic viscera are remembered. The uterus, in its normal position of ante-flexion, lies with its axis at an acute angle with the

vagina; indeed, when the bladder is empty, the fundus of the uterus approaches very close to the anterior wall of the vagina. In this position, when the uterus is forced downward, it simply tends to push the anterior wall of the vagina against the posterior wall, when it meets with the resistance of the pelvic floor; hence the vagina is not distended. In this position the force of the intra-abdominal pressure falls upon the posterior wall of the uterus, and maintains the uterus in its normal anti-flexed position. If, for any reason, the uterus becomes retro-displaced, its axis becomes parallel, or almost parallel, with the axis of the vagina. Intra-abdominal pressure falls upon the fundus and anterior wall of the uterus and the vesico-uterine pouch, and tends not to drive the cervix and the anterior vaginal wall against the posterior vaginal wall, but to drive the whole uterus downward along the axis of the vagina; thus to a greater or less degree, inverting the vagina in its descent. In this malposition of the uterus, intra-abdominal pressure, instead of being a conservative force tending to maintain the uterus at a certain level, becomes a factor of evil tending to produce procidentia uteri and prolapse of the bladder. The degree to which these displacements are carried depends, of course, upon the amount of intra-abdominal pressure, upon the laxity of the tissues in an individual case, and upon the amount of resistance met with from the pelvic floor. So much for the causes acting from above.

When the pelvic floor becomes weakened, either by laceration or atrophy of its structures, adequate support to the pelvic viscera is no longer afforded. The pelvic floor drops downward and backward, the introitus vaginæ gapes open, the posterior wall of the vagina drops away from the anterior wall, the rectum tends to bulge forward through the gaping vulva, constituting a rectocele; the anterior wall of the vagina and the bladder tend to prolapse into the introitus, constituting a cystocele; and in turn the uterus tends to come down (partly from lack of support, and partly through the influence of pressure from above), constituting a prolapsus or procidentia uteri.

The proper study of every case of procidentia involves a careful investigation into each of these factors which may be concerned in its production, and upon the proper recognition of exactly what underlies each case, depends the scientific and curable treatment of the disorder.

In my experience, by far the most important cause of procidentia, is laceration of the pelvic floor, especially lacerations involving the levator ani muscle and pelvic fascia. This injury is the primary cause of procidentia in ninety-nine per cent. of the cases which come under my observation. I see numerous cases of slight prolapsus or descensus uteri, where the uterus simply descends one inch, or an inch and a half, which are due to other causes than a torn pelvic floor. Such causes as tight lacing, hard work, constipation, pelvic congestion, etc., can bring this about. But in my experience these causes, broadly speaking, are incapable of producing complete procidentia of the uterus. There are exceptions to this rule, but only one has come under my observation. This was a case of complete procidentia in a nulliparious woman having lax tissues, who had been compelled to do laborious work with heavy lifting. Her uterus doubtless had become retroverted, then prolapsed, and, finally, had been forced down so low that it protruded between the labia. This woman had a lax, but intact pelvic floor. She was cured by changing her occupation, the use of tampons for a time, followed by a Smith-Hodge pessary.

*Treatment.*—As the primary cause of procidentia is a torn pelvic floor, it follows that if lacerations of the pelvic floor were properly repaired at the time of their occurrence, or shortly thereafter, that procidentia uteri would be prevented. In other words, the way to prevent procidentia uteri is to do immediate perineorrhaphy in all cases of laceration of the pelvic floor following labor. It is unnecessary at this time to go into the details concerning the technique of immediate perineorrhaphy. I shall simply say, that in this operation the sutures should be placed just as carefully, and in the same manner as for the secondary operation. The patient should be anæsthetized, the parts well exposed, and the suturing begun at the upper angle of the tear, no matter how high up this may be. The sutures should be tied as they are introduced, so that when the last suture is introduced and tied, the operation is completed. Immediate perineorrhaphy can be done at any time within

twenty-four hours after labor, and doubtless even later, with complete success. If, however, the suturing is postponed more than six hours after the injury has occurred, it is better to freshen the raw surfaces by scraping them with a knife. These lacerations will be found, almost invariably, to extend up one or both sulci of the vagina. They are never median, unless the tear extends through the sphincter ani, and then splits the recto-vaginal septum. It is far better to postpone immediate perineorrhaphy for six, ten, or twenty-four hours, and to have proper assistance, than it is to attempt the operation at the close of labor, when the physician is tired out, the patient exhausted, and, perhaps, without anæsthesia, because no one is present to administer the anæsthetic. The practice somewhat in vogue of putting in one, two, or three sutures from the skin perineum cannot be too strongly condemned; because all severe lacerations extend one, two or three inches up one or both sulci of the vagina, and cannot be reached by sutures introduced from the skin perineum. All that such suturing can accomplish is to unite the unimportant superficial structures of the skin perineum, while the torn levator muscles are not included in the sutures.

The other factors which produce procidentia are those which increase intra-abdominal pressure (such as tight lacing and laborious work), retro-displacement of the uterus (which favors procidentia, because in this position intra-abdominal pressure tends to drive the uterus along the vagina, and parallel with its axis), pelvic congestion, brought about especially by constipation, sub-involution of the uterus and other pelvic organs, and in rare cases, the presence of a tumor adds to the weight of the uterus. A perfect prophylaxis of procidentia uteri involves the prevention or cure of all of these conditions.

When procidentia really exists certain conditions are always present. The uterus prolapses into or through the vulva, and its proper ligaments are overstretched. The anterior vaginal wall and bladder are prolapsed, and in many cases a large cystocele is present. The posterior vaginal wall and rectum have dropped downward and backward with the pelvic floor; and the rectum may, or may not, have bulged through the open introitus, if so, constituting a rectocele. In many cases the uterus will be found elongated, constituting the condition known as supra-vaginal elongation of the cervix. This is brought about by stretching of the cervical tissue, rather than by its hypertrophy. In such cases the fundus uteri occupies a higher plain in the pelvis, than would appear from the position of the cervix. In many such cases the uterus measures four, five or even more inches; and yet often reducing the procidentia and putting the woman in the knee-chest posture, it will be found to measure only three or four inches.

The method of operating which I have followed in treating this class of cases is to do a high amputation of the cervix, anterior colporrhaphy, and Emmet's perineorrhaphy. The amputation of the cervix reduces the size and length of the uterus, and through the way it is done draws the vagina to a higher point in the pelvis. The anterior colphorrhaphy takes up the slack under the bladder and makes the anterior vaginal wall a straight line from the pubic arch to the cervix, as it should be. The perineorrhaphy restores the pelvic floor to its normal condition, and gives permanent support to the bladder and uterus. Naturally the uterus should be maintained in ante-flexion, and if after an operation it does not assume this position, a Smith-Hodge pessary is introduced to maintain the uterus in its normal position. Practically, I have seldom found this necessary even for a short time, and of the very many operations which I have done for procidentia, so far as I know, not a single woman is now wearing a pessary.

In amputating the cervix, the woman is placed in the lithotomy posture; the field of operation made asceptic; the cervix is seized with bullet forceps and drawn down; the vagina is cut loose from the cervix; the bladder is stripped off in front, and the sub-peritoneal tissues stripped off behind. The lateral attachments of the cervix (the bases of the broad ligaments) are now ligated and cut away. About an inch of the cervix is now amputated; then the cut edges of the vagina are stitched to the stump of the cervix, the mucous membrane of the vagina to the mucous membrane of the cervical canal; thus covering in the stump, and securing primary union. This operation draws up the vagina to the cervix at its new level. Also, it very materially reduces the size

and weight of the uterus, not only through removing part of the structure, but by the process of involution which it induces.

Anterior colporrhaphy is next performed. In those cases in which the bladder has not been markedly prolapsed a simple oval denudation is made, which is closed with a continuous catgut suture in two layers. In marked cases of cystocele Stoltz's operation is done. This consists of a circular denudation, with a single running suture placed like the drawing-string of a bag, and tied in the same way. The operation is quickly done, and secures a firm point of cicatricial union under the bladder. I believe that the merit of the operation consists not only in the ease and rapidity with which it is done, but also that it offers a more permanent resistance to the descent of the bladder at a future time.

Emmett's perineorrhaphy is then done, and is that part of the operation which makes the cure a permanent one. The operations upon the cervix and upon the bladder would for a time overcome the prolapse of these structures, but when the woman got about on her feet again, the prolapse would simply reappear were not the primary cause of the trouble (namely, the lacerated pelvic floor) repaired. In restoring the pelvic floor I have not been content with doing the regular Emmett's perineorrhaphy, but taking this operation as a basis, I have made the denudation as extensive as possible; in this way not only bringing together the sundered structures, but, in addition, making the vagina as narrow as possible, and also sewing up the vulva to a certain extent. In this way the vagina can be reduced in size, so that it scarcely admits more than the index finger—an end to be desired in every bad case of procidentia.

In doing amputation of the cervix, a few heavy silk ligatures are used, but most of the operation is done with catgut. It is well to have a silk ligature to pass through each lip of the cervix into the cervical canal, so as to have two silk ligatures at the point where the future os uteri is to be, as otherwise the raw edges of the cut vagina might unite, which would necessitate making an external os at a later day. The basis of the broad ligaments can be tied off with catgut, and almost all of the sutures about the cervix can be of this material. This is a decided advantage, as it is not desirable to make traction upon the perineum to remove these sutures for some weeks after the operation. In doing the colporrhaphy, when the oval denudation is made, the wound is closed usually with a running catgut suture placed in two tiers. Usually one or more silk sutures are introduced to act as stays. In operating upon the pelvic floor, the upper sutures are of catgut and the lower ones of silk. This obviates the necessity of removing the upper sutures, which embrace only the cut vaginal walls, and which are used only to help in narrowing the vagina. Silk is used in suturing the torn ends of the muscles and for the external sutures. The ones in the skin are removed in a week, those in the vagina after two weeks.

It is wise to treat patients having procidentia for some weeks prior to their operation. The uterus should be reposited and kept in its position by means of tampons. In order to secure this object it is at times necessary to put the woman to bed. In very bad and long-standing cases of procidentia, the mucous membrane of the vagina loses its proper character, and becomes very much like skin. It is of decided advantage to reduce the procidentia and to treat the condition with glycerine tampons, which helps to restore the parts to a more nearly normal condition. After the operation it is best to keep the patient in bed for at least two weeks, and preferably for three weeks, and then to permit only a very gradual resumption of her ordinary occupation. Such patients should be cautioned against straining or lifting, and should be informed that it requires weeks for a wound to become thoroughly consolidated.

It is, perhaps, wise, in this connection, to say a few words about the use of the pessary for procidentia. Excepting those rare cases in which the procidentia has occurred in spite of the fact that the pelvic floor is intact, the use of the pessary for this condition is clearly illogical. A pessary can never restore a torn pelvic floor; and if this accident has been the cause of the procidentia, any treatment except the repairing of the injury is clearly illogical, and can be only of temporary value. The pessary is a useful instrument in the treatment of slight descensus and of retroflexion of the the uterus when the pelvic floor is intact. The pessary should

be supported from below, partly by the vagina itself and largely by the encircling slips of the levator muscle. It should never get its support from the pelvic bones, which is what happens when a large pessary is introduced to hold up a procidentia when the pelvic floor is widely torn. Used under these circumstances, a pessary must be large in order to be retained, and when it is large it invariably presses against the pubic bones. It is not necessary to point out how illogical this use of the pessary is in order that its application may be condemned.

## VACCINE VIRUS.*

H. M. ALEXANDER, M. D.

Nearly a century has elapsed since Dr. Edward Jenner, the discoverer of Vaccine Virus, inoculated his first patient, and proved to the world the efficacy of his theory of vaccination, as the preventative of that dreaded disease, small-pox. As has always been the fate of every new theory, invention, or innovation in its infancy, Vaccine Virus met, for a time, with violent opposition, yet the learned Jenner lived to be feted in the streets of London, his path being strewn with flowers, and was finally tendered a testimonial of ten thousand pounds, by an Act of Parliament, in recognition of the great boon he gave to mankind. But important discoveries are slow to adoption, and owing to bigotry and superstition, are seldom appreciated fully in the age of the discoverer. The evolution of Vaccine Virus was, then, necessarily slow. Great difficulty was experienced in procuring Vaccine from the animal, and the use of the crust, taken from one person and applied to another, which is known as Humanized Virus, or vaccine, was adopted. This method was continued for many years, when it was discovered that a great number of diseases, especially skin diseases, and the most vulgar ones to which the human system is heir, were being conveyed from arm to arm.

### DESIGNATED HUMANIZED VIRUS.

We shall pass over the history of the period which elapsed from the beginning of the Nineteenth Century until the propagation was begun in America in 1870, for the history of this period, as we glean it from the writings of many authors, is very conflicting. Its efficacy as a protective agent was thoroughly proven in many instances, while there were others that left some doubts as to its ability to protect against the dread disease, small-pox. Our own experience has forced us to believe that these great deficiencies in protective power were largely due to the fact that Humanized Virus was much used, which in these cases of failure had greatly degenerated.

### SOURCES OF AMERICAN PROPAGATION.

Whether true cow-pox was found among the cattle frequently prior to 1866 is not certain, but in that year a case was found in Beaugency, France, and it was from this strain that Bovine Virus was imported into America, and its propagation from heifer to heifer introduced into the United Stated in 1870 by the late Dr. Henry A. Martin. In the decade which followed, the propagation of Vaccine Virus was begun in various sections of the country. The methods employed, however, were of the crudest nature, and much of the propagation of a dangerous character. In many instances, propagation is still carried on in unclean stables, located in filthy city alleys, where the virus produced is of necessity subjected to dangerous contamination of the surrounding filth; the cattle are usually procured from city stock yards —generally heifers—but very frequently decrepit, old cows, that have shown some organic weakness. Only an external examination of them can be made, and naturally disease-bearing tuberculosis is not always avoided. As a result, the greater portion of the Virus procured in this way, instead of affording protection against small-pox, merely produces ulcers of a dangerous and most painful nature.

### LOCATION OF VACCINE ESTABLISHMENTS.

It is important that an establishment for the propagation of Bovine Virus should

*Address before the Fourth Pharmaceutical Meeting of the College of Pharmacy, Philadelphia, Pa., January 16, 1894.

be located in the open country, where the advantages of pure air and perfect cleanliness can be found, and where every possible sanitary condition can be had. The buildings should be erected especially for, and devoted exclusively to, the propagation of Vaccine Virus. They should be models of perfection and completeness, while the water supply should be well filtered, and absolutely under the control of the propagator. Ample room should be given, that no crowding of cattle be called for. The operating should not be done in the stable, but should be in a spacious room, well ventilated, free from filth of every description, and perfectly dry, for dampness is an avowed enemy to Vaccine Virus. The stables wherein the cattle are housed should be clean, pure, and entirely free from foul or impure air.

### THE PROPER SELECTION AND PREPARATION OF THE CATTLE.

Instead of buying cheap, diseased, or decrepit cattle from city stock yards, the better plan is to rent heifers from one to two years of age, being reared by the farmers of the surrounding country for their future milkers. This enables us to use generations of the same stock, and therefore know all about them, giving the advantages of learning of the existence of any hereditary diseases that might naturally be overlooked in the most careful examination of the animal itself. When the heifers are brought to the farm, the first thing is to give them a close examination, then place them in the stables, groom carefully, and feed on bran mashes, until it is determined they are ready to become subjects. They should then be led to the operating room, and fastened. The method of this fastening differs greatly, but the one which I show you on the photographs distributed, has proven in my own hands by far the most satisfactory. By a simple mechanical arrangement the animals are easily turned over, resting on the strong portions of the ribs, near the vertebral column. They rest easily on these upholstered tables, and do not struggle, while all is done in a manner which preserves them from excitement. The inner portion of the flanks, back and above the udder, are then well shaven and inoculated with Vaccine taken from a former subject. This portion of the body is selected as it is the easiest to kept clean, and does not chafe. In some establishments the udder is selected, but experiments have conclusively proven that the udder is too warm a location, and usually results in confluence and malignancy. The abdomen, which is also sometimes selected, offers the same objection, as the animal cannot lie down to rest without lying on some of the vesicles, and developing excessive heat. After the inoculation, the heifers are taken to specially prepared stalls, where they are cared for and watched closely for an average of seven days and nights. When the vesicles are fully developed, the animals are returned to the operating room, the crusts are then removed with the handle of a scalpel, and the vesicles are thoroughly cleansed by sponging, and all foreign and impure matter removed.

### PREPARING THE POINTS.

The ivory points which are to receive the lymph which is now exuding from the vesicles, should be sterilized. They should then be placed in clamps of fifty each, so that the operator is not obliged to touch the points with his fingers. The points are coated by applying with a camel's-hair brush with which the operator absorbes the virus as it exudes from the vesicles. The points are coated twice, with the virus of two animals. The vesicles should not be irritated by the repeated application of the point to the surface, as is the case in most establishments, and which causes them to exude much serum, while the repeated handling of each point causes great danger in the way of septic poisoning. Besides this, when fifty points in one of these clamps are coated with one and the same brushful of Virus from one animal, and re-coated with another brushful from another animal, they will all be alike, which is not the case if the vesicle is irritated by a repeated application of hundreds of points to the tender surface. They should be carefully inspected, packed in glass, and bear the label of the propagator. Unscrupulous propagators, do not, as a rule, label their goods, but conceal their identity, which should always be a good reason for discarding them.

### SELLING THE POINTS.

Rate cutting and the great clamor of the cheap druggist, or the demand of sharp competition, have caused ivory points coated with mucilage to be placed upon the market at a very low figure, thus

driving the real article out for a time. These knaves, then finding that the total failure of their goods gave them much trouble, and that the druggist returned to the legitmate ones, added croton oil to their mucilage which causes a vesicle to form. The patient tells the physician that his arm is sore, and he, accepting the statement, believes the vaccine to have been all right, while the fact that it acts so quickly proves its worthlessness.

CAUSE OF FAILURES.

This brings us to the cause of failures being reported, not only where there has been actual failures, but where the physicians failed to wait long enough before making their reports. Not only do failures certainly result from the use of impure materials, but they also occasionally result from those of good source. Some few cases are insusceptible, but not many. Secondary vaccinations fail because they have been previously vaccinated, and are still protected. Other failures, even in primary vaccinations, are sometimes due to the fact that Virus was shipped in an over-heated car, and hence spoiled in transit. A still more frequent cause is that the Virus is exposed to excessive heat or moisture in the office or store of the druggist, or by the physician carrying it in his vest pocket. It can be guaranteed for sixty or ninety days, for Vaccine is not injured by age as frequently as is generally supposed, if kept in cool, dry apartments. In fact, we send it to China, Hindoostan and Palestine with success. Many physicians fail in consequence of their method of operating. We do not want to say that our method of vaccinating is the best, but we will give what we have found to be the most successful manner of proceeding, and also why we think others have failed.

HOW TO VACCINATE.

Our plan is to scarify the part thoroughly by scraping off the scarf-skin, and scratching the surface thus abraided in two directions, roughing it, so as to get the lymph retained close to the mouths of the absorbent vessels. The portion scraped should not be too large, as too large a surface often results in great violence, or an ulcer is produced where a simple vaccination was intended. We touch one side of the ivory point in a drop of water, shaking all possible off agian, then apply it by rubbing it well upon the scarified surface, depending largely for our moisture upon the amount of serum which exuded from the scarification to dampen it, and aid us in removing the Virus from the ivory point. Often this serum, with the water we have used, is excessive, when we can readily form a paste by the use of the other side of the ivory point which was not dampened in this manner. We are certain of getting a sufficient number of Vaccine corpuscles within reach of the mouths of the absorbent vessels, and to finish the operation we gently prick or scratch the arm with the point we have just used. Many physicians use too much water, and are unable to form a paste, the little corpuscles floating off, and being very glutinous, adhere to the skin; the physician thinks he has gathered them up, and finishes by getting all he can upon the scarified surface, but does not succeed in getting much else than the serum; the absorbent vessels exhaust themselves absorbing this material, and fail to get in any of the corpuscles required. Again, we have known of paste, when not finished by pricking it in, to have dried as a varnish beyond the reach of the absorbents, which had been closed by the rubbing process.

Another cause of failure is that hosts of physicians clamor for colorless points, forcing the propagator to give them as little as possible, in order to keep away from color, and then they use one point to two patients, when it was only intended for one.

VIOLENT RESULTS.

Violent results occur from the use of lymph containing filth, the use of irritating drugs, and the use of Virus that has been removed from the animal at the wrong time, for it should be taken early. They also occur from the use of cattle that are too old, which yield a great deal more Virus, but which is unnecessarily strong and irritating. Again, the violence may result from the neglect of the physicians to cleanse the arm prior to vaccination, or the use of an unclean lancet; that is, the one used continuously without being disinfected. The best way to disinfect a lancet is to dip it in alcohol after each application, and then touch it to a flame; but a more frequent cause of violent arms comes from the practice of dressing the arm after the operation by means of cotton and

adhesive strips. There is not the least doubt but that this imprisoning, as it were, is causing the most mischievous results, and often death. We emphatically say, keep the arm loosely clothed, put no dressing upon it, unless it is a protection shield properly made, and advise the patient to use the arm as little as possible, and keep it clean. With good Vaccine and the proper care you will have very few bad cases, unless you can find a very marked syphilitic history in your patient. Our experience has proven that syphilitic families with a decided history have shown a strong tendency to violent action.

SUMMARY OF DANGERS.

To sum up the dangers we might say that they come, first, from the improper selection of cattle; second, from the filthy condition of the establishments in which they are kept; its dangerous location; the plan of procuring Virus by pressure, and by carrying it to another apartment, after having been removed, instead of putting it on the ivory points warm, and allowing it to dry quickly. Packing it in dangerous materials for the sake of cheapness, the propagator either wanting to avoid correspondence with the consumer, or else ashamed of his goods, fails to put on his label. The druggist and physician looking for goods that cost less than ten cents a vaccination, sacrificing the lives of their patrons by buying dangerous Vaccine, or that which is not Vaccine at all, because it is sold to them at a cut rate. The druggist may keep a good article too long; it can always be exchanged for fresh without extra cost—this would be simple carelessness on the part of the dealer; the physician's retaining the goods in a vest pocket, or hot office; neglect of cleanliness in operating; want of knowledge of a proper method, and an over-anxious desire to protect the arm.

WHEN IS THE PHYSICIAN SAFE?

How shall the physician know when he is safe, and how shall he obtain the best results? First, by keeping in touch with the best propagators. Ascertain for a certainty that they have the proper kind of establishments, and exercise the proper care. Let the physician buy from a druggist upon whom he can depend, being certain that he is not getting cut-rate goods; be sure that the goods bear the label and full address of the propagator, that he may be able to correspond with the producer should he have any difficulty, either from failure or excessive action. Let him await for results of Bovine Virus from five to eight days, and never report until ten full days have elapsed, and to look with suspicion upon anything that acts on the second, third, or fourth day. In this way he can avoid many of the dangers and protect his patient, as well as help overcome the fraudulent practices of those who care not for the health of their fellow beings.

HOW TO REMEDY BY INSPECTION.

It has been suggested that the government assume control. To assume the role of propagator would, in this country, be a greater failure than it is to-day in those countries that have tried it. We are exporting Vaccine to-day, because it is pronounced superior to theirs, and I was informed this summer at Chicago by their own people that the Government Virus was not generally used by the intelligent classes. State propagation is not practicable for the one reason, if no other, that there is not sufficient demand to enable the propagator to keep up a continuous strain of propagation, or carry sufficient stock to be able to meet the demand when it arises. I would suggest a National Board of Health, composed of one member from each State Board, they to appoint inspectors from their number, whose duty it would be to thoroughly inspect every Vaccine establishment of the country, and to allow no Vaccine to be sold without a registry number, guaranteeing to the druggist, the physician, and the layman that the article he buys, uses, or has used upon himself or his children, has received the sanction of the proper authorities. Then, and not till then, can compulsory vaccination be justly enforced.

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THE Massachusetts State Board of Health concludes, from investigations of artificial ice, that artificial processes of freezing concentrate the impurities of the water in the inner core or the portion last frozen, that the impurities are least if distilled water is used, that the number of bacteria in artificial ice is insignificant, under the prevailing methods of manufacture, and that the amount of zinc found in ice is sufficient to cause injury from its use.—*Scientific American.*

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SATURDAY, FEBRUARY 17, 1894.

## EDITORIAL.

### THE STUFF DREAMS ARE MADE OF.

The average man spends about one-third of his entire life in dreamland, and the impressions brought from thence into normal waking life have exercised great influence on the progress of the human race. The use of the word dream is apt to result in a confusion of ideas, for the term has been applied to almost every act of cerebration, differing in any respect from the average level of mental processes; including at once that exalted condition of mind called inspiration, which enabled the seers of old to prophecy, "the old men to see visions and the young men to dream dreams," down to the reflex smile of physical comfort on the face of the sleeping infant whose mother fondly believes the angels are talking with it.

To the average human being, who is neither a prophet nor the son of a prophet, dreaming is a form of mental activity carried on during sleep when the physical being is at rest and the volitional powers held in abeyance. A recent writer* in summing up a discussion of the subject says:

"To the normal waking intellect the Sleep Land must always remain a foreign and unknown country, where the laws and customs are utterly different from those by which the waking mind lives and moves; and where even the stable verities of space and time are turned topsy-turvey. But, for all that, it is a region where there is much more movement astir than we generally imagine, and where a great deal of important business is in progress, beyond that of overhauling the animal machinery. We do not know enough of this unconscious cerebration—this commerce incessantly carried on among the brain cells—to be able to understand the full utility of such a perpetual bustle of ideas.

"Speaking very generally, one may say that during sleep the brain does an immense amount of sorting and pigeonholing of impressions received since the previous night's rest. It would appear also that some process akin to stock-taking, and the rummaging of out-of-the-

*Dr. Louis Robinson, in *North American Review*, for December, 1893.

way corners, also goes on when the judgment and will are taking holiday. Let it suffice for present purposes to say that this unconscious cerebration during sleep is undoubtedly of great utility, and is probably essential to every being with the least spark of reasoning power; and that to it, in the first place, may be attributed the phenomena of dreaming. Whether the occasional emergence of the traffic into the department of consciousness is in any way necessary to the mind in health is quite another matter, and I am inclined to think that we should, most of us, get along very well if we were never aware of dreaming throughout the whole of our lives. But we should dream, nevertheless. The evidence points conclusively to the existence of a certain amount of cerebral activity during the whole period of sleep, and there can be no doubt that the vast majority of our dreams never come to our knowledge. The storehouses of the mind are of incredible vastness. We are apt to judge of the contents of our memories by our volitional power of recollection; but the two bear as little relationship as do the treasury-vaults of a bank and the drawing power of a single depositor. Nothing that the eyes have seen, or the ears have heard, or which has once passed the turnstile of one of the other senses, is ever let go. Every face of the thousands we survey in passing through a great city, every word on every page we read, every tree and hill and stream we catch a glimpse of as we are whirled along on the railroad, every sound which vibrates on our ears from morning to night, is indelibly registered within. They may be, and most of them are, entered on the record without our knowledge, and they may remain there for a great part of a lifetime without our having any suspicion of their presence, and quite beyond the reach of our powers of recollection; but for all that they are there, and may come to light under appropriate conditions."

There are obvious difficulties to the consideration of cerebral processes of which we are totally unconscious and over which we have no volitional control, so that for all practical purposes the subject of dreams becomes limited to such cerebral impressions as are strong enough to force themselves upon consciousness during such time as the ordinary powers are inhibited by sleep. Within these limits dreaming may afford data for the profitable consideration of the psychologist, and within still narrower limits may serve to indicate to the physician obscure pathological conditions.

This is quite a reasonable supposition and indeed is generally believed by the ordinary man as a lesson from individual experience. Every one has met numberless examples of that class of dreamers whose photo-type is the man who, indulging in underdone pork, is sure to receive in sleep a visit from his ancestors. The association of ideas is the result of his personal experience, and it might not be too much to say his dream was made of underdone pork. Indeed, so firm is the conviction on the general mind that indigestion and dreaming are intimately related as cause and effect that almost every individual can, from experience, tell the stuff of which his dreams are made.

The writer quoted states elsewhere:

"Just as we are not infrequently able to localize the seat of some internal disease by taking note of the facial expression and mental disposition of a patient, so (according to the writer's experience) the cause of not a few obscure cases of insomnia can be learned from the character of the dreams which accompany the long delayed slumber. The reason is that sleep is often seriously interfered with, especially in those who have the nervous system in an irritable state from worry or overwork, by irregularities in the functions of other parts of the body which do not

attract the patient's attention when awake, but which, in that delicately balanced condition when the mind is isolated from other disturbing agencies, suffice to give the thoughts a definite direction; just as electric currents, too slight to be otherwise appreciable, will deflect the needle of a sensitive galvanometer. Thus, defective sleep very frequently results from disturbances of the digestive apparatus, or from a slight interference with the functions of the heart or lungs, of which the patient is himself quite unaware, but which will give rise to dreams of a sufficiently characteristic nature to enable an expert to diagnose the true nature of the case."

As yet however the phenomena of dreaming have been but little investigated in strictly the scientific and experimental method, and another writer, Miss Mary Whiton Calkins, in the *American Journal of Psychology*, who has made some experiments concludes that even the traditional association of nightmare and a heavy meal does not stand on very sound scientific footing. The *Medical Record* in an editorial resume of this latter article says:

"The subjects experimented upon were two in number, a man of thirty-two, and a woman of twenty-eight. The investigation was carried on for eight weeks, during which time the man had one hundred and seventy, and the woman two hundred and five dreams. They had not previously supposed themselves to be great dreamers, and the large number is accounted for by the fact that pencil and paper were kept at hand and every transient dream was at once recorded on awaking. The first point investigated was the time at which the dreams occurred. It was found that most dreams took place in the morning hours. In one case, 73.2 per cent. occurred after 4 A. M., very few on falling to sleep or before midnight. The next inquiry covered the question of the relation of the character of the dreams to the thoughts of waking life. It was found that in about fifty per cent. the character of the dream was distinctly connected with some waking thought or suggestion, while in forty per cent. some slight or vague suggestion existed.

"As to the vividness of dreams, it was found that about one-half could be classed as very vivid or decidedly vivid, so that details could be recalled and a good story written. The most vivid dreams occurred after four o'clock.

"A careful analysis of the dreams shows that during this condition the mind may exercise fairly normal activity. That is to say, the dreamer may remember correctly, imagine clearly, and think connectedly. The latter phenomenon, however, is rare. The statistics show that in the great majority of cases the dreams are associated with familiar persons and places. The subject-matter of the dreams was generally trivial, and the writer concludes that one seldom dreams of the serious problems and emotions that confront him while awake. In times of bereavement one seldom dreams of the dead. Miss Calkins considers it very improbable that the train of thought in dreams is swifter than in waking life. If she is right it destroys the credibility of a good many interesting anecdotes. Thus Napoleon is said to have dreamed of a journey, a siege, and a cannonading, and awoke while some explosion was still reverberating.

"Curiously enough, some attention is given to the subject of prophetic dreams and telepathy. While viewing the subject with commendable scepticism, the writer cites several dreams which appear to have a certain previsual or telepathic character. The relationship of certain diseases to dreams is a matter of especial interest to the physician; but here he must himself take up the subject and carry out investigations."

It will thus be seen that the subject of dreams presents an unexplored realm for the researcher, though one of interest greater, perhaps, to the psychologist than to the practicing physician, and promising richer rewards to the student of metaphysics than to the doctor who can find scarcely time enough to meet the requirements of his duties as a member of a life-saving service.

# ABSTRACTS.

## COLD HANDS AND FEET.*

WM. H. FLINT, M. D.

Many children, though apparently in very fair health, habitually have cold hands and feet. This is, indeed, such a common occurence that, in many instances, it hardly excites the attention of those to whom the care of the children is entrusted. Even if it does strike the observer as rather unsual, it is generally dismissed with casual comment, as of no particular importance. This is, in the opinion of the writer, a serious mistake, since the existence of persistently cold hands and feet seems to him the infallible index of disorder in the bodily mechanism, or of deterioration in the vital fluids, which should receive prompt attention and which, if disregarded, may lead to graver pathological conditions. This remark does not apply, of course, to those cases in which the extremities have been only temporarily chilled by exposure to cold and to moisture, and in which the natural temperature is easily restored by the agency of warmth, of dry air and of friction.

There are several unatural conditions capable of giving rise to cold hands and feet, and some of these leading factors are here tabulated in order that *Babyhood's* readers may more easily ascertain the causes of cold extremities and may, if possible, remove them, with the view to the prevention of actual disease. These conditions are: 1. Indigestion; 2. Nervous Excitability; 3. Imperfect Circulation; 4. Impure Blood. In order that the reader may readily understand the physiological mechanism by which the first two causes produce their effects, it is proper to recall the facts that the warmth of a part will depend, other things being equal, upon the amount of blood present in its tissues; and that the quantity of blood sent to the various organs is determined by a delicate double system of nerves, which regulate the calibre of the blood vessels and which are themselves controlled by nerve centers located in the brain and in the spinal cord. One of these sets of nerves contracts the muscles in the walls of the small arteries, thus partially shutting off the blood from the vessels, while the other set dilates the arteries. If the latter nerves gain control of the arteries, in any part of the body, these vessels increase greatly in capacity, and a large quantity of blood passes into them and into the corresponding veins, the surface soon becoming red and warm. An example of this physiological act is seen in blushing. Sudden pallor is, on the other hand, due to the preponderating influence of those nerves whose duty it is to contract the blood vessels.

Now, *indigestion*, the first cause of cold hands and feet mentioned in our list, probably produces its effect upon the extremities by stimulating the centers which control the vessel-contracting nerves. It is assumed that this may be accomplished either by the irritation of the mucous membrane of the stomach and of the intestines, through coarse or undigested foods, and by the stimulating products of unnatural fermentations, or by the absorption into the blood of these same irritating substances and of poisons emanating from the bacteria which are instrumental in producing fermentation of the undigested foods.

While indigestion is probably the most frequent cause of cold extremities, it is, perhaps, the most easily removed of the causes enumerated above. The writer has repeatedly insisted, elsewhere in *Babyhood's* pages, upon the necessity of checking digestive disturbance speedily, lest they lead on to actual digestive and constitutional disease. This warning he begs

* *Babyhood*, February, 1894.

to repeat and to emphasize in this connection. When, therefore, cold feet and hands betray the probable presence of disturbed, let us spare no means, whether dietetic, hygienic or medicinal, to remove any existing dyspeptic ailments before they lead to organic disease.

In cases of cold extremities from any cause, temporary relief may be afforded, by various means, while the real source of the trouble is being discovered and remedied. Much good may be accomplished by properly protecting the hands and feet. Woolen or silk stockings should be worn during the fall, winter and spring months, and should be changed several times daily, in order that the perspiration retained in the stockings be not long kept in contact with the feet. If this precaution be neglected, evaporating from the damp stockings soon chills the feet, the effect being the same as if they had purposely been enveloped in moist cloths. Brisk friction, with the hands and with dry towels, employed at the time when the stockings are changed, will greatly assist the circulation in the feet, thus promoting warmth and comfort. The shoes should be so large as not to pinch the foot, and the soles and uppers should be thick and firm. The hands ought to be protected by woolen mittent or gloves, which should be well dried, at the fire, from time to time.

*Nervous Excitability* may give rise to cold extremities. The nervous system is so delicately balanced and so susceptible to slight impressions, in this class of cases, that little shocks and irritations of the controlling nerve centers are constantly produced by influences incapable of exciting such responses in those children whose natures are more phlegmatic or apathetic. Emotions, whether of joy, of sorrow, of anger, of pleasure or of pain, may suffice, in these patients, to set the vessel-contracting nerves into action, by which the surface is deprived of blood and depressed in temperature. Nervous susceptibility, of such a high grade as has just been described, should be removed by proper management and treatment, lest it lead into functional or organic nervous disease. The cause of such exaggerated sensibility, on the part of the nerves, may be deeply hidden and may require the aid of the family physician for its discovery and its removal.

*Imperfect Circulation* may be responsible for persistent coldness of the hands and feet. The heart's action is not strong enough to propel the blood into the extremities with sufficient force and rapidity to keep them adequately warmed, the hands and feet being more remote from the central organ of the circulation than any other parts of the upper and lower members. Given this origin of the symptom we are considering, it may be of great importance for the future physical welfare of the child that the heart's action be strengthened, and that any unsuspected cause for this weakness of the circulation be ferreted out and, if possible, removed. This is true because, without healthy heart action, perfect growth and nutrition are impossible, and because heart weakness may imperceptibly develop into actual heart disease.

*Diseased Condition of the Blood* may also occasion coldness of the hands and feet. The warmth of the body (called vital heat), as well as its growth and repair, is chiefly due to oxidation occurring in all the tissues. The oxygen required for this all-important chemical process is conveyed to the tissues by the red corpuscles of the blood. If these corpuscles are diseased, so that they cannot act as efficient oxygen carriers, or if they are not sufficiently numerous to convey an adequate supply of oxygen, normal oxidation cannot take place, temperature is reduced below the normal point, and the tissues suffer from innutrition.

If this condition of affairs is allowed to continue, the child's growth must be stunted and the patient is also exposed to graver dangers from the occurrence of any constitutional disease than he would be were his blood and his nutrition in a healthy state. It is natural that coldness of the surface, due to depreciation in the quality of the blood, should show itself most strikingly in the extremities, for they are more exposed to refrigeration than the more warmly covered trunk and members. They are, moreover, farthest from the heart, the action of which is apt to be impaired whenever the blood is disordered.

In conclusion, the writer begs his readers not to neglect this apparently trivial symptom of cold hands and feet, but, being forewarned by its appearance, to seek out and remove its cause, in order that their children's natural growth and development may be promoted and that possible disease may be averted.

## APPENDICITIS.

In a lengthy article on Appendicitis in *Mathews' Medical Quarterly*, Dr. F. Byron Robinson draws the following conclusions:

1. The diagnosis of appendicitis rests on pain and tenderness in the right iliac fossa, vomiting, temperature and tympanitis. A tumor may be found in about one-third of the cases.

2. The *pain* is due to an appendicular peristalsis. It may arise from perforation. It is appendicular colic, or may be due to inflammatory invasion. The constipation is not mechanical, but *reflex*. The tympanitis is due to reflex paralysis of the bowel. The vomiting is reflex. The lameness is due to pressure on the lumbar plexus. The sudden cessation of pain is often due to the expulsion of the body into the cæcum. Adhesions may induce pain.

3. The infective invasion of appendicitis may induce œdema, hemorrhage or phlibitis into the right iliac fossa. I know of an embolus going to the liver after operation and infecting it, killing the patient.

4. The appendix resembles the tonsils, and is subject to similar temporary inflammations at the same ages in both sexes. It is lymphatic in structure. Its glandular (lymphoid) element is large.

5. About one-half of appendicitis is catarrhal or parietal, and should not have surgical interference. Relapsing appendicitis is not a dangerous malady. All suppurative and perforative cases of appendicitis should be operated on as soon as diagnosed.

6. My experience with appendicitis in children is, that it is very progressive and very fatal, and should be operated on as soon as reasonably diagnosed. It invades rapidly in children on account of its large lymphatic constituents.

7. Males have appendicitis four times as often as females.

8. The age of appendicitis is the same in both sexes—from ten to thirty years mainly.

9. The chief cause of appendicitis lies in the small size of the appendicular mouth. The mouth is guarded by a valve of mucus membrane (Gerluch's). With a small mouth objects insinuate themselves through, but irritation of the foreign body on the mucous membrane of the appendix induces it to swell and close the mouth so that the foreign body is unable to get out. It seems to the author that Gerlach's valve is larger in men than in women.

10. The vermiform appendix is the most variable organ in the body, viz., in length, situation and peritoneal environments. Hence its pathological conditions vary in position and environments.

11. Many hundreds of autopsies show that from fifteen to twenty per cent. has had appendicitis and died of other diseases. The periappendicular adhesions remain.

12. Anatomical description of the appendico-cæcal region has varied from the beginning until now. The main statement which can be made at present is that the cæcum is entirely covered by peritoneum, while the appendix always originally had a mesentery. The peritoneal attachments vary because the rapidly-growing cæcum steals away the peritoneal covering from the atrophying appendix.

13. A perforation of the appendix will nearly always open into the peritoneal cavity, but it may open into the post-cæcal areolar tissue. In this case it will open between the layers of the meso-appendix and pass over the upper border of the cæcal peritoneal covering.

14. Microbes play the chief role in appendicitis. They multiply rapidly when the appendicular mouth is closed and the appendicular secretion is changed, producing perforation and disturbed circulation.

15. The result of the closure of the appendicular mouth is irritation. The glandular secretion becomes excessive and disproportionate from the irritation of the foreign body and microbes. Deranged and fermenting secretion, confined, aids downward progress. Circulation is deranged; the veins and lymphatics become overfilled, œdema results, local or general necrosis (or gangrene) follows, and a perforation of the appendix supervenes, which induces local or general peritonitis. If limited by exudates the peritonitis will be local. But peritonitis and exudates can and are produced by microbes or their products (ptomaines) penetrating the appendicular wall, leaving no visible perforation.

16. The pain is felt in the right iliac fossa in about half the cases, and the other half feel the pain in the abdominal cavity—not localized. In general most

abdominal pain is felt around the umbilicus, that is over the abdominal brain. There is frequently a referred pain in appendicitis. McBurney's point is useless and untrustworthy.

17. In my experience in young women, frequent micturition often accompanies appendicitis. The abscess is more likely to move in the pelvis than in man. It may be due to the appendix being over the brim of the more spacious female pelvis more frequently than in males.

18. Bowel obstruction and constipation in appendicitis is reflex, not mechanical.

19. Vomiting is due to reflex irritation carried up the superior mesenteric plexes to the abdominal brain, where it is reorganized and emitted to the stomach. Every viscus suffers from reflex irritation, especially those supplied by a large plexus of nerves containing many nerve strands, as for example, (*a*) the stomach, (*b*) the small intestine, (*c*) the heart, (*d*) the kidney, (*e*) the spleen, (*f*) genito-urinary organs, (*g*) lungs.

20. The tenderness in the right iliac fossa is not uniform in location, but exists wherever the pathological appendix happens to lie.

21. The rise of temperature is due to toxic substances in the blood—infection. A subnormal temperature may be due to overwhelming the system with the toxic substance. It seems that violent irritation of a sympathetic plexus of nerve can raise or lower temperature.

22. Perforation of the appendix infects the pelvic organs of women, and the tubal and ovarian infections infect the appendix.

23. Probably ninety-five per cent. of the diseases about the cæcal region arises in the appendix.

24. In regard to operation in appendicitis it may be asserted that a low mortality in itself does not justify any surgical procedure.

25. Cases of acute appendicular perforation with diffuse peritonitis should be operated on, though recently every case is fatal. Out of every two hundred autopsies on dogs killed or dying after I had performed abdominal experimental procedure, I found no dog survive general peritonitis. I know of two surgeons of this city (Chicago) who have operated on seventeen cases of diffuse peritonitis following appendicitis, and every case died.

26. Localized abscess in the cæcal region should be incised, and if it be not too dangerous for the patient, the appendix should be ablated.

27. Subjects of severe recurrent appendicitis should be operated on for comfort and utility of the patient.

28. The cardinal principal in the operation is to manipulate the viscera as little as possible. If one evacuates an abscess in the cæcal region it seems unwise to waste time or manipulate very much in order to get the appendix; simply irrigate and drain with gauze. It is not perfect surgery, but it is *safe* surgery, which is really most perfect to the patient.

29. The various forms of appendicitis give varied results in operation. The diffuse peritonitic form gives almost one hundred per cent. mortality; the recurrent form has some eight per cent. fatality; the general mortality for appendicular operation will be not far from fifteen per cent., except in the case of individual surgeons who operate on almost every occasion. It would appear that the surgical mortality is over fifteen per cent., while from the best sources that about eighty-five to ninety per cent. recovers without operation. At this rate nature has a less mortality than the art of surgery.

30. Treves says that eighty per cent. of cases of appendicitis get well spontaneously. Talamon says that ninety per cent. get well with a certainty with no operation. Guttman treated medically one hundred cases, and four died.

31. The foreign body in the appendix is generally dried feces mixed with calcium salts, and not some solid body, so that, so far as our present knowledge goes, physicians cannot claim that swallowing cherry stones, grape seeds or fruit pips, etc., tends to induce appendicitis. No doubt some form of indigestion or colitis precedes many cases.

32. Observation and practice seem to teach less surgery on the appendix than formerly. Judgment is becoming more accurate as to what cases demand operation. Autopsies and pathology would seem to limit operative work more and more. Post-mortems are telling the more exact story of frequent appendicular lesions from which the patient recovered. The following of conservative but representative men like Treves, Guttman, Talamon, Fenges, and many others, is increasing. Yet reasonable surgery will always hold an important place in appendicular diseases, for the appendix is a useless organ.

## THE ORIGINAL OF SHERLOCK HOLMES.

It was, therefore, with great satisfaction that the reader of Dr. Conan Doyle's fascinating stories learned some time since, from the author of his being, that Sherlock Holmes was indeed founded on fact and drawn from life, and that the model for him had been a professor in the medical college in which Dr. Doyle studied. This gentleman has been the object of an extensive and pardonable popular curiosity. He is Dr Joseph Bell, of the Royal Infirmary of Edinburgh. He studied at the famous University of Edinburgh, took his degree at twenty-two, was for two years assistant demonstrator of anatomy in the university, then became house surgeon, and latterly consulting surgeon.

It is evident that the medical profession offers peculiar advantages for the development of the faculty of observation, which, indeed, is as helpful and indispensable to an ideal doctor as to an ideal detective. Diagonis is, indeed, largely detective work, and those who have the good fortune to be the patients of a "born doctor," when they had the misfortunes to be patients at all, often have occasion for astonishment at a knowledge of their condition that seems to them like clairvoyance, but in truth the result of a natural faculty for observation assiduously cultivated. It is evident that the original Sherlock Holmes has the faculty in an eniment degree.

A reporter of the *Paul Mall Gazzette* has had, and related for his paper, a highly interesting interview with the original of Sherlock Holmes. It appears that Dr. Bell has made use of his remarkable faculty not merely in the line of his profession and for the astonishment of his acquaintances, but that it has frequently, been employed in actual detective work. and in furtherance of the ends of justicel As might be expected, he has paid special attention to medical jurisprudence. The crown retains in Edinburgh a regular medical adviser in criminal cases, and this medical adviser has for some twenty years been in the habit of enlisting the services of Dr. Bell, although in these cases he has merely been retained as an expert, and has no official connection with the crown. The reporter who visited Dr. Bell was in Edinburgh to report the Ardlamont murder trial, which has attracted comparatively little attention in this country, but has excited a great and widespread interest in England and Scotland; and in this case Dr. Bell has been retained as an expert adviser for the prosecution. While he declined to give any reminiscences of his detective work that had not already been made public, he declared that whatever deductions he had been able to make that had been of service to the authorities had been "simple and commonplace." They had come from the habit he himself had formed and had tried to inculcate upon all his scholars—Conan Doyle among them—the habit of paying attention to what are commonly dismissed as unimportant things. "I always impressed over and over again the vast importance of little distinctions, the endless significance of the trifles." To what important results this habit may lead is illustrated in the facts of Dr. Bell's career, as well as in Dr. Doyle's action founded on those facts. One illustration of it is striking enough to be well worth giving in Dr. Bell's own reported words:

"This one struck me as funny at the time. A man walked into the room where I was instructing the students, and his case seemed to be a very simple one. I was talking about what was wrong with him. 'Of course, gentleman,' I happened to say, 'he has been a soldier in a Highland regiment, and probably a bandsman.' I pointed out the swagger in his walk, suggestive of the piper; while his shortness told that if he had been a soldier, it was probably as a bandsman. In fact, he had the whole appearance of a man in one of the Highland regiments. The man turned out to be nothing but a shoemaker, and said he had never been in the army in his life. This was rather a floorer; but being absolutely certain I was right, and seeing that something was up, I did a pretty cool thing. I told two of the strongest clerks, or dressers, to remove the man to a side room, and to detain him till I came. I went and had him stripped. Under the left breast I instantly detected a little blue 'D' branded on his skin. He was a deserter. That was how they used to mark them in the Crimean days, and later, although it is not permitted now. Of course the reason of his evasion was at once clear."

After one knows that Sherlock Holmes

is not entirely the creature of the novelist's imagination, but that his qualities are drawn from life, many readers must be incited to develop those qualities in themselves. In the interview from which we have quoted, Dr. Bell says, very truly and suggestively:

"I should just like to say this about my friend Doyle's stories, that I believe they have inculcated in the general public a new source of interest—the kind of interest created by Richard Jefferies and the 'Son of the Marshes.' They make many a fellow who has before felt very little interest in his life and daily surroundings think that, after all, there may be much more in life if he keeps his eyes open than he had ever dreamed of in his philosophy. There is a problem, a whole game of chess, in many a little street incident or trifling occurence if one once learns how to make the moves."—From *Harper's Weekly*.

### Professor John Tyndall.

Now, Tyndall was one of those men who bear a large share in the actual technical work of such great discoveries. But it is hard to put one's finger upon any single point easily to be apprehended by the ordinary intelligence. He taught us much, for example, about the way radiant heat is propagated through the atmosphere; about the objects which are, so to speak, opaque or transparent to it; about the effects it produces on the surface of our planet. He taught us much about how glaciers are formed, move, and are retarded, break into crevasses and freeze together again, compress themselves through gorges, or spread themselves, though solid, into lake-like expansions; and he did more towards explaining these singular phenomena than any other observer. His contributions to the sciences of light, of sound, of electricity, of magnetism, of heat, and even of biology (so far as regards the diffusion of the germs of minute organisms), are all of them most valuable. He was a fellow-worker in the triumph of evolutionism and of just and sound views about energy. But for the most part he led up towards those great developments in physical and electrical knowledge which have not yet been made and towards practical inventions which have not yet been invented. This sort of work is the most valuable of all, but it is often the most inglorious. So it comes about that Tyndall, who was himself a most careful, accurate and patient investigator, was best known as a popular expounder and an almost sensational orator. He would not have been so famous if he had not superadded Belfast addresses and Royal Institutional lectures to his real work in the laboratory and on the mountain.—From a Character Sketch of Professor Tyndall, by Grant Allen, in the February *Review of Reviews*.

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The Dangerous Communion Cup meets increasing opposition. Doctors should agitate the subject, like Dr. A. J. Longfellow of the M.E. Church in Fostoria, Ohio, who moved the following resolution: "Resolved, That the church purchase four hundred little wine-glasses and each communicant receive the wine out of a glass that no other person has used, and the bread passed on baskets or plates, and that it be not handled or broken by the preacher." This is a good second to the movement against the still more dangerous incident of alcohol in the communion cup.

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Chlorine in liquid form is now being manufactured by Messrs. Pechiney & Co., of Salindres, in France, and at the Rheinania Works, at Rheinan, near Mannheim, in Germany. The gas is liquefied by subjecting it to a pressure of 50 atmospheres (750 pounds) to the square inch and stored in strong iron vessels holding 120 pounds each. It is delivered from these vessels either in the liquid or gaseous form, and can be used in bleaching. It is said to be as economical in use as bleaching powder, while it has some advantage over that product.—*Scientific American*.

### Check.

The man who tries to take advantage of the ignorance of another occasionally gets a Roland for his Oliver. A Boston man once, in England, seeing a laborer digging flints out of chalk, pompously asked him if he thought they grew.

"Sure," was the reply, "I know they do."

"Then put some flint on a table, and see how much it grows in a year."

"And you, sir," said the laborer, "put a potato on the table, and see how much it grows in a year."—From the "Editor's Drawer," in *Harper's Magazine* for February.

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*January 16th, 1894.*

### REMOVAL OF BULLET FROM THIGH OF A MAN WHO HAD CARRIED IT SINCE THE BATTLE OF SHILOH—32 YEARS.

DR. W. O. ROBERTS: Last week a gentleman fifty-two years of age, consulted me with a tumor in the popliteal space of the right leg. The tumor was about the size of a guinea-egg, located just at the outer side of the inner ham strings. He furnished the following history: At the battle of Shiloh while in a stooping position to fire, he was struck by a shot just above the knee. The bullet as he said ranged upward; the wound was probed some six or eight inches, according to his statement, without finding the ball. He was in the hospital over six months before the fistulous tract closed. He then left the hospital and went back to his command, and soon after re-entering the service while under march his leg became very sore, considerably swollen, he became very lame and was sent back to the hospital. At this time he was in the hospital at Atlanta, Ga., where he was seen by Dr. Westmoreland. Soon after the doctor saw him, he made a free incision in the upper part of the thigh, about four to six inches above the point of entrance of the bullet, and removed quite a quantity of pus and broken down tissue, but did not find the ball. This wound was slow in healing, but after it healed he had no further trouble until a few months ago, when he began to complain of stiffness about the muscles of the back part of the thigh, pain just above the popliteal space and tenderness on pressure. He noticed in sitting down that part of the limb which came in contact with the seat gave him great discomfort, and only about three or four weeks before I saw him he detected in the location I have mentioned, this tumor. I cut down upon it and removed the bullet which I exhibit. You will observe the peculiar shape of the ball. One point of interest is that there is a phosphatic deposit on one side of the bullet.

#### DISCUSSION

DR, J. W. IRWIN: This is rather a singular coincidence. Last Friday a gentleman came in my office complaining of loss of memory, and pain in the back of his head extending down his neck, which had been in existence for ten years. He sought relief chiefly on account of his memory. He had been a private in the Northern Army, and had received a shot at the battle of Shiloh; the ball had entered his face along side of the wing of the nose just above the alveolar process of the gums. The bullet had never been found. I made an examination of the case and found along side of the origin of the ligamentum nucha some enlargement, and, upon closer investigation, I found that the bullet was encapsulated there. I suggested that the bullet should be removed. He was not then prepared to have the operation done. He went home and I have not heard from him since, but what course this bullet took I cannot tell, anyway it had caused loss of memory and had a very decided effect upon the intellectual faculties. It had lodged in the back part of the neck near the first dorsal vertebra.

DR. A. M. VANCE: The case reported by Dr. Roberts is certainly a very interesting one. I cannot believe that the tract explored by the surgeons could have been the tract of the bullet, it must have been due to clothing or something else. This bullet could not have gotten in the position where Dr. Roberts found it after having gone up the thigh. The case illustrates what a false guide a probe is often times in gun shot wounds, and how it may go in almost any direction after it gets into the cellular tissue. I believe that the bullet passed directly through the man's thigh in a backward direction, and finally settled down in the position Dr. Roberts found it.

DR. I. N. BLOOM: I would like to inquire whether any practical results have been obtained by probing for bullets with the electrical apparatus such as was used in Garfield's case?

DR. A. M. VANCE: Several new instruments are on the tapis for this purpose just now, but what practical results have been brought about I do not know.

DR. T. P. SATTERWHITE: The case is very interesting and shows what nature does in encapsulating foreign bodies. I remember several year ago removing from a man's arm a piece of glass about ½ inch long, which had remained in the arm for twenty years without producing any disturbance, until a few months before it was removed.

DR. P. GUNTERMANN: When I was a boy 15 or 16 years of age, I remember that there was a retired Major in our little town, who had been a soldier under Napoleon, having passed through all the wars, had been to Russia, the Battle of Waterloo, etc. He

took great pride in exhibiting his right leg in which there were five bullets. These bullets were of the old fashioned large variety, and could be distinctly felt. He had several inducements to have them taken out but he refused, stating that he "wanted to take them with him," and he did carry them with him to the grave. They never gave him any particular trouble. He was not a very large man, about the ordinary size and weight. I simply mention the case to show how long bullets may remain in the tissues without giving rise to any serious trouble. It was forty years after receiving these bullets in his leg that the old Major died.

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DOUBLE HYDROSALPINX AND CYSTIC OVARIES.

DR. L. S. MCMURTY: I present for examination a specimen of hydrosalpinx and cystic ovaries. The symptoms in the case were menstrual irregularity, general pelvic pain and irritation of rectum and bladder with sterility. The patient is about thirty-two years of age; she has one child, six years old. Two years ago she consulted a surgeon who operated for laceration of the uterine cervix without any improvement of her condition. In making a vaginal examination I detected a mass in each lateral pelvic space. The abdomen was opened, and the specimens which I exhibit removed. She is making an easy recovery. The operation was performed ten days ago. The Fallopian tubes are as large as average size sweet potatoes, and so distended with serum that they would readily have broken and emptied into the peritoneum. The ovaries are each converted into a monocyst. By careful manipulation I succeeded in removing them without rupture.

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DR. J. W. IRWIN, read a paper entitled,

THE DANGERS OF INFECTION BY PERSONAL CONTACT WITH DISEASES NOT REGARDED AS ACTIVELY CONTAGIOUS OR INFECTIOUS.

See page 232.

DISCUSSION

DR. T. P. SATTERWHITE: I think it is very well that persons who are invalids should not sleep with any one. I agree perfectly with Dr. Irwin in that particular. I see no harm, though, for two healthy persons to sleep in the same bed. It is a very common thing now for a man and wife to occupy separate beds.

DR. I. N. BLOOM: In France, Austria, Italy, and Northern Germany it is very rare for more than one person to occupy the same bed. The beds are single and placed some distance apart. In Vienna it is very difficult to find a large bed. What they call a large bed there is a canopy affair not nearly as wide as the double beds in this country, and only designed for one person. As a rule they only have a bed three feet wide, the husband and wife each having his or her own bed.

I believe a reform in this matter would be a decided benefit to people generally.

DR. J. M. KRIM: There is no question in my mind about consumption being contracted in the way suggested by Dr. Irwin: I remember a case where a man died of consumption; his wife nursed him until he died. She married again about six months afterward, and died of consumption eight months later. Her second husband also died of consumption. No predisposition by heredity or otherwise could be traced in either of these cases, and there can be no reasonable doubt but infection occurred in the way Dr. Irwin has stated.

DR. J. W. IRWIN: I would like to ask if anybody has had any experience with the examination of air respired from the lungs of consumptives, and in what way the disease is transmitted, whether by absolute contact with the lips, or through the respired air, or both?

DR. P. F. BARBOUR: We cannot deny that it might be by both. I should think though, it would be more likely to occur through the inhaled air.

DR. J. W. IRWIN: But there is no very definite record of the germs of consumption having been found in the respired air from the lungs of persons suffering from that disease.

DR. C. G. LUCAS: I think it has been proven by experiments made by a German observer (whose name I have forgotten) that the tubercle bacillus is transmitted through the medium of the respired air. In these experiments guinea-pigs were suspended in a cage before tuberculous cattle, and in a very short time evidence of tuberculosis were found in the guinea-pigs.

DR. J. W. IRWIN: I asked that question because in a former discussion of this subject the point was raised that the bacillus of consumption had never been found in the respired air from the lungs of persons suffering from that disease. The literature on the subject is very meagre, and there is some doubt as to whether the bacillus has ever been found in the respired air or not. But if it has not been found, that does not prove that the respired air does not contain the germs of the disease. Experiments with guinea-pigs are not conclusive from the very fact that even their close confinement may bring on wasting diseases. They are the easiest of all animals that we know anything about to contract disease.

Some years ago a series of experiments were made upon dogs which were confined in the manner spoken of by Dr. Lucas, by taking the sputa from consumptives and diluting it and putting it into a spraying apparatus and once a day spraying the dogs with this diluted sputa. The dogs were strong healthy animals furnished by a pound keeper. On the twenty-seventh day after the spraying began the first dog was killed, and he was found to have a number of tubercles in his lungs. On the thirty-fifth day the second dog was killed, and he was found to be still more affected. The third dog was killed in two months and both lungs were infiltrated with tubercular deposits. That was an experiment to show the contagiousness of consumption through the sputa in a diluted form, rather than through the respired air. Two other dogs were sprayed with a solution of calf brains in the same way and under the same confinement, and they were killed in two and four months after the spraying began, and no trace of disease of any kind was found in them. When we come to consider all the facts and all the circumstances between the husband and wife, we cannot attribute it altogether to respired air, in that the husband and wife are so likely to kiss each other and the germs may find their way to the lips and in this way they may contract the disease rather than from or through the respired air. Be that as it may the weight of authority seems to point to the expectoration as the most dangerous source from whence the disease comes to those in close contact with it. That the consumptive expectorates and that is deposited on the ground, on the floor or on the bed, that it dries and it is stirred up in the dust and it is inhaled. The germs of the disease in this way enter the lung rather than through the respired air from the consumptive. Some fallacy seems to me to exist in this statement, in that the husband (when the wife is the subject of consumption) is the one who contracts the disease (or vice versa) rather than other members of the family and the one most likely to contract the disease would be the chambermaid who sweeps the apartment, for we all know what a cloud of dust even a single sweeping will cause, and the dangers of inhaling the poisonous products of the expectoration from that source to the chambermaid would seem to me to be very much greater than the inhaling of the dust in a much lesser way by the husband or the wife. I rather think we have the principle cause in personal contact together with the inhalation, and while the germs have not been reported as found in the atmosphere, I am still inclined to the belief that they may yet be found in it and in view of all the facts that whether it be the germs, or whether it be the toxalbumens or other poisonous products due to the waste of tissue coming from the body, the infection is due to personal contact with the consumptive, and those coming in closest contact are in the greatest danger and are the first to become affected; that sweeping the room is not dangerous to the person sweeping or to those coming in contact with the dust which rises, as personal contact with the patient suffering from the disease.

DR. P. F. BARBOUR: There is one point in this connection that might be investigated, that is whether the husband or children are more liable to contagion.

Of course the nursing child is predisposed to tuberculosis, in fact the tubercle bacillus has been found in the milk of the nursing mother. But children past beyond that age playing about the room for instance, inhaling the dust from sweeping, etc., would they not be as liable to infection as the husband or wife?

DR. J. W. IRWIN: Investigations have been made in that line, and results go to show that the husband or wife as the case may be, is very much more liable to contract the disease than any other member of the family.

DR. A. M. VANCE: I saw a statement some time ago which showed that more widows and widowers died of consumption in proportion to numbers, than any other class of people; proving that those who have been previously healthy, and the wives or husbands of consumptives die in vastly greater proportions than the ordinary populace.

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CONTINUED REPORT — INTENSE HEADACHE FOLLOWING A BLOW; OPERATION.

DR. W. O. ROBERTS: I would like to continue the report of a case which I presented to this society some little time ago, the man who had been struck on the head nine years ago and had been suffering with the most intense headache nearly ever since. This headache steadily increased in severity, and I had him admitted to the City Hospital. The night before I operated upon him, it required a grain of morphine hypodermatically to quiet him. At my clinic I simply raised a horse-shoe flap including the cicatrix in it; I found no trouble with the skull, so replaced the flap, and strange to say he has been entirely relieved of all distressing symptoms, headache, etc., and he is now working at the hospital in the capacity of night nurse.

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EXTRA-GENITAL CHANCRE.

DR. I. N. BLOOM: Some time ago I read a paper before a meeting of this society upon the subject of "Extra-Genital Chancres." I have recently had a very interesting case of

this character, which was referred to me by a prominent surgeon of this city. The patient is a lady forty-five years of age; she separated from her husband and has not had sexual intercourse for fourteen years. She came to me with an undoubted syphilitic eruption all over her body. There were characteristic scabs in the hair, and slight glandular enlargements. The case was so plain that I made a positive diagnosis at first sight. Her first visit was in the evening, and as the light was not very good, I requested her to come back the next day. On her first visit I made a very close examination in an endeavor to discover the initial lesion or its site, but was unsuccessful and did not find it the next day. I told her what was the matter with her, and that I was very anxious to know how she contracted it. On the third visit, five days after I first saw her, she called my attention to a sore at the site of the wisdom tooth which was wanting in this case, on the right side. She told me that this sore had been there for a number of weeks, just how long she did not know. Then later she informed me that there was a gentleman whom she had known all her life, who had been in the habit of kissing her, and she found out afterward that this man had syphilis. I am satisfied that the point of infection was posterior to the last molar tooth, and the case I am reporting is a chancre. The woman afterward developed mucous patches in the vagina which are sufficiently rare to deserve notice. The case to me is a very interesting one on account of the unusual site of the chancre, and that this is the point of infection I think we have positive proof. I will also state that the glandular enlargement was very slight, which is contrary to the rule. Usually in cases of chancre about the head you will find very decided glandular enlargement.

DISCUSSION.

DR. J. W. IRWIN: The case reported is a very interesting one; the history of it, however, is defective. I do not believe that the case was one of contagion through the gum; contagion through the gum would not necessarily be followed by mucous patches in the vagina. A chancre on the lips would not necessarily be followed by this condition of the vagina, and, I doubt if there is a case on record of this character, where the history of the case has been clinically truthfully obtained. Of course these patients always deny anything like carnal intercourse. I cannot believe that the lady told the truth.

DR. I. N. BLOOM: It is quite a serious matter to be told that your judgment in the case of a woman is wrong, when you yourself know the woman and know of her and form your ideas as to whether she is telling the truth or not; but I should think it would be a great deal more difficult for a person who has never seen her to make any such assertion. In a case of this kind I think the doctor who makes the examination by close questioning can usually tell whether the truth is being told or not. This patient was a very intelligent women, and I believe she was sincere in what she said, as she seemed very anxious herself to find out how infection could have occurred. As for mucous patches necessarily following a chancre, that is a mistake; mucous patches need not necessarily follow a chancre anywhere. I believe it is the exception rather than the rule, that mucous patches are found in any situation following chancre. I have seen several cases where there was an undoubted characteristic chancre, which was followed by a very slight eruption and nothing else. One of the cases I have had under observation for three years, and no further sign of syphilitic disease has manifested itself. Mucous patches are just as liable to occur in the vagina if the chancre appears on the tongue as if it makes its appearance on the genitals; in other words a chancre may be followed by its characteristic sequelæ, no matter where it occurs. So that no argument can be deduced as far as the criticism of Dr. Irwin is concerned; I fail to see where he has established a single point, or that any idea of the diagnosis can be obtained from either side—of the mucous patches wherever they might occur, or from his judgment as to whether the lady was telling the truth. We are bound to be governed to a certain extent in these cases by the impression that the patient give us. A person who can read character thoroughly is, of course, able to form a better judgment than those who cannot. While I am skeptical about a great many people, and frequently listen and disbelieve patients, in this case I am thoroughly convinced that the woman was telling the truth, and that the point of infection was the situation I have mentioned. The sore back of the gums was undoubtedly a chancre, and the eruption was certainly syphilitic.

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REPORT OF SEVEN CASES OF ANTERIOR VENTRAL FIXATION OF THE UTERUS.

DR. W. H. WATHEN: There are various methods of treating retro-placed uteri with and without operation. Usually these cases are treated by a properly adjusted pessary, etc., which may give temporary or permanent relief, but there are cases where the pessary does no good and causes pain; and where there is inflammation of the pelvic structures, or adhesions, its use is dangerous. Where the uterus is not held down by adhesions, and the tubes and ovaries are healthy there are very few cases where a laparotomy for ventral fixation of the uterus

would be justifiable. But we cannot always positively decide that there is no disease of ovaries or tubes, and that the uterus is free of adhesions. In laparotomy work adhesions are often found that could not be diagnosed in previous examinations. Where there are no adhesions, the Alexander operation has been followed by good results in well selected cases, where the operation was correctly done and a properly adjusted pessary worn for several months; but this operation was contra-indicated in the cases I wish to report.

CASE 1.—I operated two weeks ago upon Miss M., of Indiana, aged thirty, who had been an invalid for many years and had ¼ grain of morphine hypodermatically, frequently repeated. Menstruation had been very painful for ten years. Her nutrition was poor and her inhibitory powers nearly destroyed. In a digital and bimanual examination I found the uterus retro-flexed and adherent, but could detect no disease of the ovaries or tubes. When the abdomen was opened, the uterus was found adherent to the pouch of Douglas, and the ovaries were so cirrhotic that there was but little healthy tissue. One tube was inflamed, but no pus was found in it. The ovaries were not larger than the end of my little finger. The adhesions were separated and the tubes and ovaries removed. The uterus was then fastened to the anterior wall at the lower point of the incision by two silk worm gut sutures introduced through the entire thickness of the abdominal wall and into the uterine tissue, under the peritoneal layer including one inch transversely, one suture being introduced on a level with the tubes and the other half inch higher in the fundus. Before tying the sutures I sacrified superficially that part of the uterus that came in contact with the abdominal wall. The woman had no untoward symptom, took no morphia after three days, suffers no pain, is out of bed, says she is well, and I feel sure will be entirely restored to health. The uterus is firmly adherent to the abdominal wall.

CASE 2.—Mrs. C., from Indiana, was operated upon three years ago; her uterus is still held in position. She became pregnant some months after the operation, and induced an abortion at the fifth month? She again became pregnant and the child was delivered at term. She is now well and her uterus adheres to the wall. In this case I operated by introducing silver wires through the walls upon each side of the wound, carrying them through the broad ligaments, including the round ligaments, but not the Fallopian tubes.

CASE 3.—A little over two years ago I operated upon Miss S., of Cincinnati, removing one ovary and tube which were badly diseased and bound down by adhesions. I used silver wire in this case as in case two, carrying it through the stump on one side and through the broad ligament on the other side, including the round ligament. Her uterus is still in position and she is restored to health. She had been an invalid for several years and unable to attend to her domestic and other duties.

CASE 4.—Mrs. J., of Indiana, was operated upon eighteen months ago. The urine and abdominal peritoneum were united by two buried silk sutures. Here uterus is still in position, and she is relieved of the symptoms for which the operation was done,

CASE 5.—Mrs. P., of Central Kentucky, was operated upon eight months ago. She was an invalid for many years. Her ovaries were cirrhotic, and were removed. Her uterus was sutured to the abdominal wall by passing a silk worm gut-suture through the stumps on each side. I saw her two months ago, and the uterus was still in position. From a very thin, nervous little woman she has grown to be quite fleshy and is restored to health.

CASE 6.—Mrs. L., of Louisville, was operated upon seven months ago. The uterus was sutured to the abdominal peritoneum with a buried kangaroo tendon. I saw her last week and her uterus is antiflexed and adherent. She was very much improved and says the operation has cured her. The ovaries and tubes were in a healthy condition and were not removed.

CASE 7.—Mrs. B., of Southern Kentucky. Ovaries and tubes healthy and were not removed. Uterus was held in front by silking worm gut sutures carried under the peritoneum of hhe uterus and brought out through the abdominal wall and fastened as in the first case. The sutures were not removed for two weeks. I did not scarify the uterus, and when the sutures were removed, I found that the uterus had returned to its abnormal position.

In some of these cases the sutures were removed within seven days, and the uterus is still adherent. Where the buried sutures were used, of course they were encysted or absorbed. In no case did I leave the sutures as long as fourteen days except in the last one, which is the only one of the seven cases in which the uterus did not remain adherent. In future I will always sacrify the uterus and I will either use the same method followed in cases one and seven, or use the buried silk, kangaroo or catgut suture. I have operated by other methods which I will report at another time.

Polk, Wylie, Dudley, and other operators, have treated retro-placed uteri by laparotomy and shortening the round ligaments before they leave the abdominal cavity.

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*A Clinical Text-Book on Medical Diagnosis.* For Physicians and Students. Based on the Most Recent Methods of Examination By Oswald Vierordt, M. D. Authorized Translation, with Additions. By Francis H. Stuart, A. M., M. D. Third Revised Edition. 8vo. pp. 700. With One Hundred and Seventy-eight Illustrations, many of which are in colors. Philadelphia: W. B. Saunders, 1894. Price, Cloth, $4.00; Sheep, $5.00; Half-Russia, $5.50. Sold by subscription only.

This is the third edition of the English translation from the German of the well known work on medical diagnosis, by Prof. Vierordt, of the University of Leipsic.

That it has reached its third edition since 1891, together with the fact that it has been further translated into Italian and Russian, evidences its appreciation by the profession at large.

Taking the book as a whole, it is a master-piece and ranks probably next to Von Jaksch. Slight exceptions may be taken to some of the statements, but these can scarcely impair the value of the work as a unit. For instance, in describing the method for counting red corpuscles, he directs that the blood shall be diluted with a *three per cent.* solution of sodium chloride. This is an error not confined to Vierordts' diagnosis, but is noted in two or three other works including even Von Jaksch, and suggests a strong probability of copying one from the other, rather than the outcome of a clinical experience in blood work. A salt solution of this strength rapidly crenates the red blood corpuscles so that their enumeration is almost impossible. If salt solution is used at all it should be only six-tenths of one per cent. in strength—but in recommending this diluting fluid the author is not up to date, as it was clearly shown two years ago by Daland, and more recently corroborated by other observers, that by far the best fluid for diluting the blood is a two and one-half per cent. solution of potassium bichromate.

In counting blood corpuscles he says, use a magnifying power of fifty diameters. This must be an oversight as most authorities agree upon five-hundred diameters as the proper magnification.

He quotes from V. Jaksch, Osler, Dock, Shattuck, and others, as stating that a positive diagnosis of malaria can be made by the presence or absence of the plasmodium; which statement is misleading, for while the recognition of this parasite makes sure the diagnosis, our failure to find it in the blood does not positively exclude malaria.

In the section on "Examination of the Urinary Apparatus," we object to the statement that "exceptionally in health, there is found in the urine albumen, sugar, bile acids and fat." In describing the qualitative tests for albumen, Heller's, which is the most delicate test of all, is not even mentioned; and so, too, in speaking of sugar in the urine, Fehling's test which is very delicate, is not given as a *qualitative* test, but in recommending it as a *quantitative* method, he directs that Fehling's solution should be made by dissolving thirty-four thousand, six hundred and thirty-nine grammes of sulphate of copper in 500 c. c. of water; which is just one thousand times as strong as is correct. "Roberts' differential density method," the most practical quantitative method for the physician, is omitted.

There are, however, so many points of excellence in the work, that these few exceptions should not detract from its very great merit. Under the name of *Plegophonia* is described a method of percussion devised by Scherwald which gives the same information as vocal resonance, and is substituted in those cases where we do not wish the patient to speak aloud, as in hæmoptysis and peritonitis. It consists in ausculting the lungs while a second person, or the patient himself, percusses upon the trachea.

The microscopic examination of sputum is very fully and well illustrated. The chapter on examination of the digestive apparatus is thorough and gives the naked eye and microscopic appearances of abnormal and normal secretions in the feces and gastric contents; including also intestinal parasites which are illustrated with many plates.

The nervous system, occupying 135 pages, is examined in detail and introduces numerous cuts and diagrams.

Then follows an appendix describing Laryngoscopic and Ophthalmoscopic examinations of the throat and eye, and lastly a consideration of those bacteria which are concerned in the diagnosis of internal diseases, including those of suppuration, erysipelous, gonorrhœa, anthrax, malignant œdema, typhoid fever, tubefculosis, leprosy, cholera and the bacillus of Finkle-Prior, closely identical with the cholera germ.

The work is a valuable addition to any medical library and is attractively mounted.

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*The Modern Climatic Treatment of Invalids with Pulmonary Consumption in Southern California.* By P. C. Remondino, M. D. The Physicians' Leisure Library, 1893. Geo. S. Davis, publisher, 25 cts.

This neat little book contains ten chapters, and is replete with valuable hints to invalids seeking climatic treatment. Not only is the climate described, but also the best method of travel and the cost of living is given. The book may be profitably read not only by consumptives about to migrate to California, but also by physicians who advise their patients to seek this climate.

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*Clinical Gynecology; Handbook of Diseases Peculiar to Women.* By Thomas More Madden, M. D., F. R. C. S., Ed. Obstetric Physician and Gynecologist, Mater Misericordia Hospital, Dublin; formerly Examiner, Conjoint Board, Royal College of Surgeons and Apothecaries Hall, Ireland. Consulting Physician, Hospital for Sick Children; Ex-Master National Lying-in Hospital, etc., etc. With 259 illustrations and 545 pages. Published by J. B. Lippincott Co., Philadelphia, 1893.

The author has carefully embodied in this

volume many valuable and important facts, derived from his own experience of careful study and observation made at the bedside; an experience which covers almost a quarter of a century and during which he has been able to separate the "chaff from the wheat."

It certainly is within the memory of all when gynecology and obstetrics were taught by only one member of the college faculty, and diagnosis and treatment of pelvic diseases were still somewhat obscure. Since, however, the mists have been cleared by the united efforts of our French, English and German confreres, much has been written, said and done to place gynecology upon a more scientific basis, and a race began among the various eminent authorities, in which refinements of diagnosis, statistical tables of work done, as well as various methods of treatment took their respective places.

It is with a mingled feeling of pride and gratification that America accepts the kind recognition our author sees fit to bestow; when he says, "Should we, however need, as we all sometimes do, further light to guide our steps in the often dark and difficult paths of gynecology, it is not to France or Germany, but to America that we may best turn for our guidance; inasmuch as modern gynecology, unquestionably, owes its present development chiefly to the influence and teaching of the American and British schools of medicine."

"Thus, the marvellous achievements of modern intraperitoneal surgery now daily exemplified in both these great divisions of Anglo-Saxon gynecological practice, and in the latter more especially by the results obtained by Spencer Wells, Lawson Tait, Keith, Bantock, Doran, Thornton and countless other specialists in the operative treatment of ovarian and uterine diseases formerly considered beyond the possibility of radical remedy, are but the fruition of the skill and courage of an American surgeon. Had we no other reason than this for gratitude to our transatlantic brethren, it should be sufficient for us to recall the memory of that first ovariotomist, who in a remote Kentucky village, alone and under the most unfavorable circumstances, successfully accomplished what the leaders of surgery in the great centers of European science, from Ambrose Pare to Hunter and Lizars, had long previously dreamed of, but had not ventured to attempt, and so inscribed the name of Ephraim McDowell in imperishable characters on the annals of medicine and humanity."

In the chapter devoted to the Methods of Examination and the instruments necessary, he makes two important introductory remarks too often lost sight of; first, that of all gynecological instruments the skilled hand of the surgeon is the most important; second, that every examination should be preceded by the liberal use on the hands of hot water, nail brush and some antiseptic soap.

The author's consideration of the sound and its importance as an aid in making a diagnosis, is not borne out by most of the American gynecologists, although great care in its use is advised. The dangers in using it are so much greater than any possible knowledge gained regarding the exact position of the uterus, since by so doing it may unintentionally become the repositor, which the author expressly condemns, and thus relight a smouldering fire since the position of a freely movable uterus can, as a rule, be determined as well, if not better by the bimanual method.

The chapter devoted to Injuries of the Perineum and their treatment, contains valuable hints regarding its protection during the second stage of labor. He further advises that any laceration extending beyond the fourchette, which might prove a probable channel for sepsis if neglected, should be dealt with immediately after the expulsion of the placenta. After describing all known methods used for a secondary repair, he ends with the description of Duke's method which has been so productive of good results in the author's hands that he uses it almost exclusively.

Alexander's operative treatment for backward or downward displacements or any modifications thereof, are rejected by the author as impracticable, since they seldom deal with the cause, only relieving a symptom; the ligaments being elastic, will be likely therefore to stretch again.

We regret, however, that the method of treatment advocated by Schultze should find favor with him, though he recognizes its dangers, for after having quoted from the experiences of Macan, A. J. Smith and others, he says: "The dangers of Schultze's method are the risks of hemorrhage from the freshly separated surfaces, of which Smith relates an instance, or of subsequent peritonitis, which according to the same writer, will not occur if a thorough examination and proper selection in the cases so operated on be previously made."

Considerably space is devoted to the various and varied modern treatments of the diseased pelvic organs. The author has given this subject careful study, describing in detail all the new theories, supplementing many such with good wholesome advice and thereby checking the young enthusiast from accepting too readily those "fancy operations that may more safely be demonstrated on the lecturer's diagram board than in a patient's body;" and yet with all, we are somewhat surprised to find that he approves of aspirating per vaginam, a hydro- or pyo-salpinx, repeating this operation two or three times, if needed, placing such treatment under the head of conservatism. To our minds the walls of the hydro- or pyo-salpinx are left and perhaps other smaller pockets in the tortuous tube. The patient's health is far from being restored, since this residue often acts like dry tinder ready to ignite on the slightest provocation. In speaking of catheterization of the tubes he states that while he knows it can be done in abnormally dilated tubes, he believes it to be by no means devoid of danger. We cannot do other than heartily agree with the author, when he condemns "nor-

mal ovariotomy for epilepsy or insanity" as a species of malpractice, but we feel certain that should, however, patients afflicted in the above mentioned manner, and both history and local conditions (diseased appendages) be present, he would not hesitate to relieve her of, at least, *one source* of nerve irritation; and his experience has also, no doubt, shown that some of the operated cases by an inexperienced or careless hand, have suffered and thus served to intimidate often, not only another patient but also the operator.

In cases where removal of the appendages becomes necessary, he carefully describes the various steps of the operation.

There are several points on which American operators differ somewhat in the teachnique; for instance, drainage is generally used for a definite purpose, where pus has been present or when a large surface denuded of its peritoneum, and is decided upon before the wound is closed; the experience of most operators having been rather too unsatisfactory to rely on placing the drain secondarily; nor can we understand the necessity for cauterizing a stump after careful and secure ligation.

The after treatment also differs somewhat, since absolute rest of the stomach for at least twenty-four to forty-eight hours, has produced the best results, while the author advises chicken jelly four to five hours after operation, if wished for. The enema of Liq. opii sedativus in a wineglassful of iced champagne and Lithia water given after the operation, is also new to us.

The author takes up in turn the consideration of diseases of the uterus and their treatment, the complications sometimes following the puerperal period, ectopic gestation, etc., each being well worth careful perusal.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE SAINT LOUIS MEDICAL AND SURGICAL JOURNAL

for January contains a paper by Dr. Edward Jackson, entitled

**A Study of the Relation of General Disease to the Development of Cataract.**

In brief, the points emphasized by the author are:

In general, senile change does not produce cataract, but predisposes to it.

The efficient determining causes of cataract are both ocular and general.

The general causes of cataract are not particular diseases, as diseases are usually described and classified, so much as physicial conditions liable to arise in the course of various diseases.

The nature, prevention, and removal of these general conditions that underlie the development of cataract offer promising fields for scientific study.

The professional supervision necessary for the making of such a study is demanded by the interests of the individual patient.

Speaking more scientifically, the study of a cataract case should include the careful testing of the vision at regular intervals.

The further examination of the eyes to determine in how far impairment of vision is due to cataract, and in how far it is due to other causes. The careful watching of the patient for other symptoms of impaired general health, especially for faults of circulation, digestion and assimilative metabolism.

Particularly at the first appearance of cataract, and at seasons of its rapid increase, would such a study of the case be of importance.

Dr. Homer M. Thomas discusses the subject of

**Pharyngo-Mycosis,**

meaning thereby a parasitic fungoid condition of the pharynx, manifesting itself in white patches of varying size resembling those seen in follicular tonsillitis, except that the mucous membrane about them preserves its normal hue. The tonsils, pharyngeal wall and base of the tongue are apt to be invaded. However numerous these small whitish projections may be, each spot is isolated, and they never form a continuous mass. After the tonsil, the glandular subtissue at the base of the tongue is most frequently affected; and the growth here may be extensive, the masses attaining the size of a pea. In some cases mycosis involves all parts of the pharynx. His experience in these cases leads him to believe that the galvano-cautery treatment is the most nearly a specific in the management of this disease of anything we have.

The other papers in this issue are: "Excision in the Treatment of Spina Bifida, with the Report of a Case," by Dr. John B. Roberts, which has already been published in THE MEDICAL AND SURGICAL REPORTER, for January 8, 1894, page 15, and a continuation of the translation, by Dr. Charles Everett Warren, of the "Prognostic Aphorism," by Dr. Gabriel Reignier.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

for February. Dr. Solomon Solis-Cohen contributes a paper on

**Vasomotor Ataxia—A Contribution to the Subject of Idiosyncrasies.**

The following is the author's summary of the paper:

1. By the term *vasomotor ataxia*, it it proposed to designate the condition of instability of the mechanism of circulation present in certain persons and characterized by abnormal readiness of disturbance with tardiness of restoration, of the equilibrium of the cardiovascular apparatus. The manifestations are most strikingly displayed by the heart and

by the peripheral vessels of the extremities, but analogy indicates the occurrence of similar phenomena in the vessels of the glands, and of the viscera, more especially those of the kidney, of the gastro-intestinal tract and of the brain. They may occur apparently spontaneously, but often there is a recognizable cause. Among the influences acting as excitants, are temperature, especially cold; toxic agents formed in the body, or introduced from without; visceral or internal reflex excitation and emotion. The stimulus may be applied centrally or peripherally, but in either case the resulting phenomena indicate a defect of central inhibition; the expression, probably, of functional or nutritional aberration in the great ganglia of the visceral nervous system, in the medullary centres, or in both. The morbid anatomy is uncertain, and the results of necropsies necessarily inconclusive.

2. Vasomotor ataxia may be acquired as a sequela of disease; in many cases it is congenital; in some cases inherited; the condition is not rarely present in several members of a family.

3. In some cases the phenomena are of paretic, in others of spasmodic character. Usually the two kinds of phenomena are displayed in varying degree in the same patient. Whether spasmodic or paretic the symptoms are suggestive of incoordination. They are always in some degree paroxysmal.

4. In exophthalmic goitre, especially, such cases as are produced by emotion or are markedly intermittent, is found the extreme type of the "relapsing" variety of vasomotor ataxia.

5. The form of Raynaud's disease, known as "local syncope" furnishes an extreme type of the "constrictive" variety; while "local asphyxia" exhibits phenomena of both abnormal relaxation and abnormal constriction of the vessels.

6. Between these two extremes are numberless gradations down to the slighest departure from normality; while even the extreme symptom-group represent merely exaggerations of phenomena that under certain conditions occur in normal individuals.

7. Dermographism is an essential feature of vasmotor ataxia, and in most cases factitious urticaria can readily be produced by cold or by pressure or by both; mottlings of the skin, certain peculiar markings of the nails, telangiectases and stigmata are common.

8. There is usually a hemorrhagic tendency, as shown by ecchymoses, petechiæ, epistaxis, hæmoptysis, hæmatemesis, hæmaturia, and retinal hemorrhage.

9. Even in the absence of hæmaturia, red blood-cells are often found in the urine; uric acid, urates, and oxalates are likewise common; the presence of albumin, tube-casts, and cylindroids is less common, and is usually intermittent. Glycosuria has been observed.

10. In many striking cases there has appeared to be morbid alteration of the thyroid gland.

11. The action of the heart is usually rapid, irregular, and easily disturbed; palpitation is common, and intermittent tachycardia has been noticed. Hæmic and functional murmurs are not uncommon.

12. Among others symptoms and morbid associations observed are anæmia, hysteria, drug idiosyncrasies, urticaria, local œdema. hyperidrosis, angina pectoris, and pseudo-angina, organic heart disease, pulmonary tuberculosis, asthma, hay-fever, vertigo, migraine and other forms of headache, transient hemiopia and other visual disturbances, persistent mydriasis, astigmatism, myopia, menstrual irregularities, intermittent polyuria rheumatism, rheumatoid arthritis, contractures of digits, chorea, epilepsy, neurasthenia, neurotic dyspepsia, gastralgia, enteralgia and membranous enteritis—most of which are doubtless fundamentally related, as effects of a common cause, or as secondary results.

13. In making the diagnosis of simple vasomotor ataxia, it is necessary to exclude primary organic disease. The occurence of such disease later does not invalidate the original diagnosis. The development of pulmonary tuberculosis in some cases is probably a sequence of vascular and atrophic disturbance in the lung. Cardiac hypertrophy and renal lesion may likewise be among the results of disordered circulation.

Dr. Edward P. Davis discusses

**The Toxæmia of Pregnancy: Its Diagnosis and Treatment.**

By the term *toxæmia of pregnancy* we understand a condition occurring in the pregnant woman in which toxic material is present in the body to excess. The mode of productions of the toxins, or poisonous waste, which threaten the pregnant women is not clearly understood though the author thinks it is in all probability due to bacteria. He urges most strongly the careful chemical and microscopical examination of the urine of all pregnant women. The treatment must be instituted with reference to promoting the action of five excretory organs—namely, the kidney, liver, intestine, skin and lungs. A milk diet is indicated in the author's opinion, but when nutrition suffers from the monotony and distastefulness of milk, we should not hesitate to give a more liberal diet. Fish and oysters, the white meat of fowls, fruits in abundance, and the more digestible sort of bread, fresh and nutritious, form a usually acceptable diet. Pure water must be taken but not in excess, as it is possible to seriously embarrass the kidneys by a sudden increase in the amount of fluid taken. Tea had better be omited, while the diuretic effect of coffee is sometimes of value. The occasional use of calomel and soda to promote the action of the liver and kidneys is of service; but should be followed by a purgative producing free and liquid stools. For this purpose salts of potassium should be avoided because of the irritant properties produced by potassium when introduced into the fluids of the body. Colocynth is a convenient and efficient drug for this purpose. The bath and pack are the only efficient remedies which experience suggests in promoting the excretory action of the skin. Where the hot bath is depressing,

the warm bath, accompanied by the ingestion of a small quantity of hot water, is of decided value. This may be well taken just before retiring, thus avoiding the danger of exposure to cold following the bath. Where a condition of moderate toxæmia exists, or continues for a long time, yielding to treatment with difficulty, great benefit will be found from gentle massage; this should include the limbs and back, avoiding the abdomen. It may well be given at night, followed by the bath, and often secures for the patient a refreshing sleep. The importance of fresh air in these cases cannot be overestimated.

As regards the cardinal principles of treatment, the author is opposed to the use of sedatives and narcotics; the patient's need is for elimination, and that must be secured as promptly as possible. The sedative effect of eliminative treatment is often remarkable. In the face of threatened eclampsia, our duty lies in the prompt emptying of the uterus. If an anæsthetic is required, the author favors chloroform. In his experience, it is a mistake to employ drugs which tend to depress the patient, and favor the occurrence of œdema; such as pilocarpine. When stimulation is needed, he has seen benefit from alcohol, digitalis, and in cases of eclampsia when labor had terminated and exhaustion threatened, in the hypodermic use of strychnia.

The remaining papers is this issue, are: The conclusion of a paper by Dr. W. W. Keen, entitled: "Four Cases of Brain Tumor, in Three of which operation was done—two operative recoveries—ultimate death in all;" "On Ascites connected with Nutmeg Liver," by Dr. John Syer Bristowe, and "A Contribution to our knowledge of Epidemic Cerebro-spinal Meningitis," by Dr. Simon Flexner and Dr. Lewellys F. Barker. This paper is illustrated with several woodcuts, and one colored plate showing sections of the spinal cord of a patient dead from the disease. The paper will be concluded in the next issue of the journal.

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BABYHOOD

for February contains an article on "Cold Hands and Feet," by Wm. H. Flint, M. D. See page 246.

Dr. D. J. Milton Miller writes of

**The Evils of Indiscriminate Drug Giving in Infants and Children.**

While the writer does not insist that there shall be no domestic medication, he does protest against the reckless and haphazard use of drugs by the laity for all manner of supposed and real illnesses in children. He refers to the great abuse of laxative drugs, and states that castor oil, magnesia, and rhubarb are the most commonly used and abused drugs of this class. Among the alkalies, soda and soda mint are much used in the nursery for flatulence, nausea, and sick-headache, when the diet is really at fault.

The use of opiates, however, in the hands of the unintelligent is the most reprehensible. Children are peculiarly susceptible to this drug, and cases of death are on record, for which it is responsible. Administered in small doses continuously it brings about a low condition of the system, attended with constipation and failing appetite.

The emetics, epecac and hive syrup, are in common use in the nursery and are valuable in the hands of an experienced mother in cases of croup, but should not be used for more protracted ailments, as bronchitis and whooping cough. With reference to external medicines, the writer says blisters should not be used. Mustard plasters need caution in their use. No drops should be instilled into the ear for ear-ache or to cure a discharge. Sore eyes should be promptly seen by a physician.

Finally, the ailments of childhood have a tendency to self-cure, and the parents should avoid drug giving or give only simple remedies, lessen the diet and keep the child in bed or in the room; and if improvement does not speedily occur, a competent medical adviser should be sought.

Dr. Chas. G. Kerby contributes an article on

**Dentition.**

He says that the effect of this process on a child's organization is greatly overestimated, and bases some deductions on a thousand cases of this character. He divides the whole number into three groups: "The Breast Fed;" "The well-managed Artificially Fed:" "The badly Fed." In the majority of the first class the teeth were cut with practically no disturbance. In a very few there was irritability and restlessness, with some rise of temperature. The second class, or well-managed artificially fed, experienced no serious inconvenience. There was, however, more of a tendency to gastro-intestinal complications. To the third class, the badly fed, belong the great number of unfortunates who are given any and all sorts of food before the system requires or the digestive organs can bear such a diet. These are the infants who are said to "teeth hard." They have vomiting, diarrhœa, convulsions, fever, bronchitis, skin diseases, rhinitis, adenitis, otitis, stomatitis, coincident with teething; and the part which it plays in the matter is a very small one. The majority of the infants of the third class are rachitic and are far more liable to catarrhal troubles.

Irritability, restlessness, slight fever and gastro-intestinal derangement are the only symptoms that would be connected with dentition. The writer has never seen "tooth cough" or "tooth bronchitis," nor has he been able to trace a positive connection between dentition and skin diseases, tonsilitis, adenitis, stomatitis or convulsions. A fourth class, few in number, is the delicate offspring of healthy parents, such children often suffer from dentition.

A pernicious belief among the poorer classes is that a bronchitis need not be treated and that a diarrhœa is beneficial during the teething process. The giving of drugs for irritability and restlessness is seldom necessary. Gum-lancing is rarely required.

# PERISCOPE.

## THERAPEUTICS.

### Cocaine Wakefulness.

An interesting case of wakefulness by cocaine is reported by J. W. Stickler (*Medical Record*, January 13, 1894). The awakening effect of cocaine was not overcome by comparatively large doses of chloral and opium, as will be seen in the following instance: For the pain of toothache a patient took into his mouth nine grains of cocaine in solution, a small portion at a time, holding it till the accumulation of saliva became so abundant that he had to spit it ont. He began using the cocaine in this manner at 5 p. m., and did not cease till 10.22 p. m. the same evening. As it was then bed time he thought he would make sleep certain by taking twenty grains of chloral. Immediately after taking the latter drug he took into his mouth some more cocaine and went to bed. He "swashed" the cocaine solution about in his mouth awhile, then spat it out, turned on his side and tried to go to sleep. Sleep, however, did not come; on the contrary, he did not even become drowsy. Having lain awake till midnight, and not feeling sleepy at that hour, he took, as nearly as he could tell, about *one teaspoonful* of laudanum. He went to bed again and remained awake till three o'clock. Sleep lasted only two hours. Following this there was headache.

### Tuberculin Treatment in Egypt.

According to the *British American Journal*, Schiess and Kartulis give results of treatment with tuberculin in forty-eight tuberculous patients. They find that in the Egyptian climate the treatment is harmless if commenced with small doses, and even patients with anvanced phthisis may be treated by this method. They have compared their cases with others in which, though tuberculin was not used, the other conditions were the same. Their conclusions are in favor of the use of tuberculin; by its aid they say, commencing pulmonary tuberculosis gets well certainly, and in a few months, while advanced cases may also recover, although more slowly. Very severe cases, with vomicæ, hectic fever and night sweats, are unsuitable for this treatment. Scrofuloderma got well more quickly than lupus and tuberculin was also found useful in certain tuberculous affections of the joints and bones, in combination with surgical treatment. The Egyptian climate is, they think, especially suitable for the tuberculin treatment.

### The Treatment of Convulsive Attacks by Anæsthetics.

In the *Medical Record* of October 31, 1893, W. S. Magill described what he termed a "new and rapid method of anæsthesia," which consist principally in the administration of ethyl bromide first, this being continued by that of chloroform. In a later note (*Medical Record*, January 13, 1894) Magill invities attention to the utility of this combined process of anæsthesia for the abortive treatment of convulsive attacks in eclampsia, epilepsy and hysteria. The rapid action of the ethyl bromide-abolition of reflex action in thirty to sixty seconds, serves frequently to abort completely the convulsion; and in case of persistence of the tendency to convulsions (subintrans), the continuance of anæsthesia with chloroform prolongs the therapeutical action *ad lib*. Theoretically the stimulus of the salivary and sudoral glands (organs of elimination), exercised by the inhalation of ethyl bromide, should be particularly useful in eclampsia, and other convulsions of toxic origin.

## MEDICINE.

### Hot Water in Acute Alcoholism.

Burson (*North American Practitioner*, April, 1893) presents a series of eight cases of acute alcoholism treated by the administration of hot water in cupful doses, every hour, or more or less frequently. They were all males, and all gave a history of habitual alcoholism. One case was complicated with contusions; one with a fracture of the tibia; two with pneumonia; one with la grippe, and one with a traumatic hæmothorx. One had been given bromide of potass. (30 gr.) and choral (15 gr.) every hour for twenty-four hours, and one bromide (30 gr.) alone for five hours, with little sedative effect; and another had been given small amounts of whisky for three days without appreciable influence. All were confined to bed; some were restrained forcibly, and all received a cupful of hot milk every two hours as nourishment. The delirium averaged from two to three days after the treatment had been started, improvement beginning shortly after the beginning of the treatment. The author holds hot water to be decidedly indicated to relieve the inflammation of the gastric mucus membrane; to wash away the mucus covering it; to increase the inter-arterial blood pressure, and diminish the cardiac rate which have both been modified by the alcohol, as well as to quiet the nervous system and soothe the kidneys. It is also of great aid in removing the alcohol present, mixture being readily formed between warm water and alcohol.

### Typhoid Bacilli Conveyed Through the Air.

Formerly the spread of Typhoid fever through the air as a medium was regarded as a common occurrence, later this idea was no longer adhered to, as soon as it became known that a specific micro-organism was essential to the production of the disease, and that the agent could only be disseminated through the air in a dried condition. To-day

the question has been again brought forward. Various experiments and observations have been made with a view to ascertaining whether typhoid bacilli are capable of being transferred through the air. Still the re[illegible] thus far carried out lack two important [illegible] rst, the positive identification of the [illegible] bacilli; and Second, the duration of their vitality in a dried atmosphere.

The author in his experiments fulfilled these conditions scrupulously, and arrived at the conclusion that typhoid bacilli are conveyed to the air in a dried state from garbage and clothing, and that the bacilli retains their vitality for from several days to two weeks. —Prof. Uffelmann, (*Wien. Med. Presse.*)

### Flies and the Diffusion of Pathogenic Bacteria.

Dr. Simmonds' investigations on the transportation of cholera bacilli by flies, are of interest in that they give in the form of a definite experimental observation what has long been almost common knowledge. It is well known that flies that have access to tuberculous sputum take the tubercle bacilli into their intestines. If the flies are axamined histologically sometime after these bacilli may be demonstrated with the utmost readiness by the ordinary methods. It is probable, indeed almost proved, that other disease germs, such as the bacillus anthracis are carried from point to point by flies and now this has been superfically proven in the case of the cholrea vibrio. Dr. Simmonds placed a number of flies, which had from time to time settled on the viscera, etc. of a cholera case on which he was performing a port-mortem examination, in a flask large enough to allow of their free movement. As soon as they had been moving about long enough to insure their having got rid of most extraneous particles (about three-quarters of an hour) they were placed in a tube containing suitable nutrient gelatin, from which plate cultures were made. In a couple of days these plates were covered with colonies of the cholera bacillus, and the proof was complete. The influences to be drawn are obvious. The humble fly-paper vender is a far more useful and important personage than has yet been acknowledged.—*Brit. Med. Jour.*

## SURGERY.

### Transplantation of Free Cutaneous Flaps Containing Subcutaneous Adipose Tissue.

After combatting the opinion that all vital changes cease in a flap immediately the blood current ceases, he showed that circulatory currents continued for some time after removal of the flap, and furnished the first agglutinative material. It is evident that these current will be more lively, the more rich the flap is in blood vessels, and Diffenbach has shown that free flaps adhere more easily if one causes them to become congested by previously tapping and rubbing them. He operated with complete success on four patients, in the following manner:

After the application of Esmarch's bandage to the upper extremity, he struck for two or three minutes the upper and inner part of the arm with a rubber hammer. Then he cut a quadri-lateral flap of slightly larger dimensions than the loss of substance, detached it from the subjacent aponeurosis on three sides, leaving it attached by a pedicle turned towards the wrist. The ulcer was then vivid, and all bleeding stopped. He then removed Esmarch's bandage, and in a few minutes the flap became red and turgid. Its attachments were cut with strong scissors, and the flap was carefully applied to the loss of substance. He used gauze, or lint, as a dressing.—*Hirschberg, Frankfort.*

### Bremann (Halle). Treatment of Gunshot Wounds of the Abdomen.

A resume of his conclusions, based on observation of cases, is:

1. In all gunshot wounds of the abdomen, accompanied immediately with signs of a lesion of the stomach or intestine, or of a severe internal hemorrhage, laparotomy should be done at once.

2. Laparotomy is also urgently indicated in cases where the seat and the direction of the projectile admit the possibility of a wound in the stomach or intestine.

In support of this statement, he quotes MacCormic's statistics, that ninety-nine per cent. of patients not operated on will die.

### Korte. "Intestinal Obstruction by Billary Calculi."

The author has operated on three patients with the above condition, with two cures and one death. In all the cases the stones, although they were not very large, were so fixed that they could not be pushed forward or backward. Two were situated in the ileum, and one in the sigmoid flexure. The clinical symptoms were those of a very grave strangulation.

Medical treatment produced no good result. The calculus was easily found, the intestine was opened by a longitudinal incision, the stone removed, and the wound sutured.

## OBSTETRICS.

### Chloroform in Labor.

Dr. Eldrige C. Price says: If the pains are very sharp, I generally give chloroform, but only to take off the sharp edge of the pain and not for one moment to produce insensibilty. I call for a tumbler that is wide at the top,or perfectly cylindrical if I can get it; if that cannot be obtained a mug. Take a fine sponge or an old hankerchief, or a small napkin or a piece of muslin rag, that will fill the glass nearly half full, pour about a half teaspoonful of chloroform on the cloth and as soon as the pain comes on hold the glass inverted about half an inch

from the patient's nose. As soon as the pain passes off invert the tumbler on a marble top stand, or on a dinner plate, which prevents the evaporation of the chloroform but retains the vapor,so that it will smell stronger when you take it up again than when you put it down. As soon as the pain returns again use the chloroform as before. Add more chloroform when necessary. If I wish to produce insensibility I put an extra quantity of chloroform on the glass and let the patient inhale without interruption until unconscious. Then and only during the pain the patient does not become unconscious, but can scarcely get done thanking you for the relief.

I have never known the least unpleasant symptoms to occur from giving chloroform in this manner; but if profound insensibility is induced it is very apt to arrest the pains for from half an hour to an hour.—*New York Medical Times.*

## ARMY AND NAVY.

U. S. ARMY FROM JANUARY 21., 1894, TO FEBRUARY 10, 1894.

Colonel Joseph R. Smith, and Colonel Bernard J. D. Irwin, Assistant Surgeons General, U. S. Army, are detialed to represent the Medical Congress, to be held at Rome, Italy, March 29–April 5, 1894, and will proceed to the place designated atthe proper time.

Lieut. Colonel Francis L. Town, Deputy Surgeon General, U. S. Army, is relieved from duty at Fort Porter, New York to take effect on the expiration of his present sick leave of absence, and will report in person to the commanding General, Dept. of the Missouri for temporary duty in the office of the Medical Director of that Department.

Frst Lieutenant Euclid B. Frick, assistant surgeon, United States army, is relieved from duty at Fort Keogh, Montana, and ordered to Fort Townsend, Wathington, for duty at that post, relieving Captain Robert R. Ball, assistant surgeon. Captain Ball on being relieved by Lieutenant Frick, will report in person to the commanding officer, Fort Monroe, Va., for temporary duty. First Lieutenant Madison M. Brewer, Assistant Surgeon, will, upon the arrival of Captain Ball, be relieved from temporary duty at Fort Monroe, Va., and will return to his proper station, Fort Riley, Kansas.

Leave of absence for one month is granted Captin Reuben L. Robertson, Assistant Sureon U. S. Army, with permission to apply for an extension of one month.

The following named officers of the Medical Dept. are relieved from duty in this city to take effect upon the completion of the present course of instruction at the Army Medical School and are assigned to duty at the stations hereinafter designated:

1st Lieut. William W. Quinton, Asst. Surgeon, Fort Riley, Kansas; 1st Lieut. Thomas S. Bratton Asst. Surgeon Fort Niobrara, Nebraska; 1st Lieut. Deane C. Howard, Asst. Surgeon, Fort Buford, North Dakota; 1st Lieut Alexander S. Porter Asst. Surgeon, Fort Keogh, Montana; 1st Lieut. William H. Wilson, Asst. Surgeon, Fort Leavenworth, Kansas.

Leave of absence for two months, with permission to go beyond sea, is granted [illegible] Robert M [illegible]ford, January 18, 1894, U. S. A.

1st Lieutenant William Brooke, Asst. Surgeon, is relieved from duty at Fort Leavenworth, Kansas, to take effect upon the arrival of 1st Lieut. Wm. H. Wilson, Asst Surg. at that post, and ordered to Camp Pitot Butte, Wyoming, for duty.

## NEWS AND MISCELLANY.

A board of medical officers will meet, Monday, April 16, 1894, in Washington, D. C, for the purpose of examining candiates for appointment to the grade of Assistant Surgeon, in the Marine Hospital Service.

For further information address,

THE SUPERVISING SURGEON GENERAL,
U. S. Marine Hospital Service,
Washington, D.C.

### Smallpox.

There is not much change in the smallpox situation. In this State there are nine points where the disease exists, five of them in Berks County, and at nearly all of them under complete control. The case found at Williamsport on January 26th is the first new infected locality reported in three weeks. This city has, so far, escaped and the outlook in the State is hopeful. New cases are daily found at Chicago and New York, and the disease is slowly increasing in both cities. A case was reported at St. Louis, and one at Cotton Hill, Ill., the origin of both being traced to Chicago. On January 22d two cases were removed from the old Homeopathic Hospital on Ward's Island, and three days later one was taken from the Insane Asylum on Ward's Island. A short time ago there was a case found in one of the public schools of Boston, and on January 27th three cases were discovered in the Cook County Hospital, Chicago. The existence of the disease has also been reported at several places in Virginia near the Tennessee line.

### Higher Requirements for Entrance to Medical Colleges.

The Illinois State Board of Health amended the schedule of requirements for admission to medical colleges by taking out of the hands of the colleges the examination in the elementary branches of education, and requiring either a certificate or diploma from a literary and scientific college or high school or, at least, a second grade teacher's certificate. A curriculum of studies for schools of midwifery was also adopted. A committee was appointed to draft an outline of sanitary work throughout the State, and the secretary was ordered to issue a "preventive disease" circular on tuberculosis.

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# ORIGINAL ARTICLES.

## SOME GENERAL CONSIDERATIONS OF PNEUMONIA.

LOUIS FIELDING HIGH, M. D., Woodburn, N. C.

Pneumonia stands preëminent among the diseases of which there has been much written and more said. It is not a disease that has been evolved from the march of civilization or sociological advancement. But who can deny that its prevelance has been increased by the modern ways of living, which, among some, are so much in discord with the laws of health as to produce a weak body incapable of resisting unsanitary influences?

Primeval man was exposed to the influences productive of the disease, like as we of to-day. Lurking everywhere, it has its victims, from the highest class and from the lowest; its subtle influence prevailing along the ranks of life from infancy to old age.

Notwithstanding the great advancement of medicine in the direction of an exact science, we have gotten but a little way from the views of past years in the treatment of this important disease. The great power of the microscope—that has been so faithful in its work and fruitful in results that by its aid surgery has eclipsed in advancement all the sciences during the last two decades—has not given to diligent investigators a sufficient acquaintance with the real cause of the disease to the extent of formulating a specific treatment nor the production of immunity. It it said that immunity to the disease has been produced, but that statement is not entirely free from doubt, though there is truth enough in it to lead us to hope its realization.

In reviewing the subject, it is striking to note the difference of opinion that exists in regard to the treatment of this disease. The want of harmony on this point is but a call for more definite information relating to its cause, pathology and treatment. Many theories have been advanced by earnest and observant workers, each hoping to give a better understanding or a more accurate comprehension of the cause or some feature of the disease bearing ultimately upon its mortality rate. But, as yet, we are in a state of uncertainty and doubt.

The old idea that pneumonia is caused by cold and exposure to meteiorlogical influences, now rests upon a questionable basis. The discovery of the bacillus of pneumonia by Fränkel and Pasteur gave encouragement and hope for a new order of means in dealing with the disease. But the fulness of that hope has not yet been realized. The evidences of its germic origin are still lacking in positive proof in all cases. Yet, while the exact part taken by the pneumococcus in the pathological process is not at present well understood, its constancy in pneumonic sputum as well as the success of inoculation experiments, is sufficient reason for the anticipation of a future mode of treatment that will have to do with the *disease* and not the *patient*. When once we are sure that the pneumococcus causes pneumonia and that we cannot have pneumonia without this germ, then will we leave the uncertain methods of treatment that have been battling the disease as far in the past as the history of medicine extends.

With the advancement of medicine and the establishment of more rational methods

of treatment of disease in general, we cannot claim high attainments in the treatment of pneumonia. The treatment of a half-century ago, though it was depressing and is sometimes called "murderous," gave results quite as favorable as the more modern stimulating and heart-tonic treatment. The mortality ranges from 3 to 35 per cent.; its average under all circumstances and methods of treatment is 20 per cent. If there is any improvement in the statistics since the days when all cases of pneumonia were bled and given depressing doses of tartar emetic, it must be due to the advancement made in the way of combating disease by nutritious and predigested aliment, rather than to medication. It may be true when many writers say they have not lost a case of the uncomplicated disease in a goodly number of years, but on trial it is found that their methods are not followed by the success claimed for them. Our test of another's treatment may in some point be faulty, still it may perhaps be well to look with some degree of skepticism upon statistics that give a death rate of ½ to 1 per cent. There is probably an error somewhere. The many and conflicting modes of treatment means at least one thing, and may be more, i. e., they are all inadequate of cure and prevention. The truth of the foregoing statement is the strongest presumption of its absolute microbic origin; it negatively demonstrates the presence of a germ or its product.

My experience in the treatment of pneumonia has not been of long duration. But it has been to that extent where I have seen some die in spite of treatment, and others recover without it. The natural tendency of the disease being to recovery much of the credit given to medicine really belongs to the natural resistance of the patient, or the mild nature of the attack. When we see eminent authorities endorsing special drugs, or lines of treatment diametrically opposed to each other, it must be that they, by a nice balancing of judgment, get in their work at one very particular turn of the disease. Truly, there are periods of the disease, in some cases, when cardiac sedatives, tonics or stimulants are the rational mode of treatment, but nothing could be more absurd than to give a patient some one, or all of these, for the very simple reason that they have been used in pneumonia. In some cases depressants may lessen the heart's action, and by slowing the circulation increase its nutritive functions and to a limited extent, strengthen the resistance of the tissues being acted upon by the infecting agent. Drugs that have a tonic effect on the heart and raise arterial tension, may, by contracting the arterial walls, lessen the migration of leucocytes and inflammatory exudation. Diffusible stimulants support the powers of life under the burden of depression. But all these means simply modify particular conditions, and leave the primary course, whatever its nature may be, uninfluenced and operative.

Venesection is being warmly advocated by men noted for their professional skill and experience. Preëminent among them is Dr. Hiram Corson, of Plymouth Meeting, Pa., a man of sixty-five years' experience. I think he bleeds in nearly every case and with very favorable results. Dr. William Pepper recently said (MED. AND SURG. REPORTER): "With continued caution, but, on the whole with increasing confidence, I find myself resorting to blood-letting." As a result of a careful review of venesection, I believe it has a place in the treatment of pneumonia that cannot, in the present state of enlightenment upon that disease, be filled by any other measure at our command. It can be beneficial by its effects on and through the circulation, lessening the volume of blood and so disgorging the right heart. It is self-evident that the engorgement and damming back of the blood upon the heart through the pulmonary circulation, is in direct ratio to the extent of obstruction and area of consolidation. As a result of such changes there is imperfect interchange of gases in the lungs, with a deficiency of oxygen and a harmful amount of carbon dioxide in the blood, all of which tends to increased heart-action and denutrition of the tissues. Though the heart's action is increased the circulation is sluggish, as is manifested by the cyanosis; the slowly moving blood favors the formation of heart-clot, adding to the dangers of pneumonic blood to coagulate or deposit fibrin in the heart or on the leaflets of its valves, a not infrequent occurrence. So we see the possible good that may follow the abstraction of blood in selected cases. In my humble opinion the time to bleed

is at the beginning of consolidation, for thereafter it is that the strain is put upon the heart; then cardiac engorgement begins and it is not yet enfeebled by overwork, and possibly before its endothelial lining is effected, which, as pointed out by Prof. Adolf Lesser, of Breslau, is not an unfrequent companion of pneumonia.

Theoretically, the urgency for bleeding is as the amount of consolidation; but a full and accurate comprehension of the condition present is necessary, if we would use this means for humanity's good.

## MEDICINE FOR A QUARTER OF A CENTURY.*

P. J. FARNSWORTH, A. M., M. D., CLINTON, IOWA.

An eminent physician and teacher of old New York, twenty-five years ago, said to his class, that "after all he needed but five medicines to cope with any ordinary disease." As it was my good fortune to have been a student under the teachings of that distinguished professor —his patients were multitudes and his success phenomenal—I have endeavored to go back in memory to the five noted medicines and something of his account of them.

It will be a surprise to our modern practitioners of polypharmacy, when they are named—Mercury, Opium, Quinine, Antimony and Iron. At that time these were a host of remedies. We have added largely to the list since, a flood of them, whose virtues are proclaimed by the myried press, and whose potencies are vouched for by the multitude of the profession. It may be well for us to consider what advantage we have gained, and what advance we have made over the old doctor.

We still retain Mercury. We have come to a new understanding of its action, but for its use we have reached few conclusions that the old doctors had not learned from their experience.

The old professor was chary of its use, but the practice of the older generation, who had used it as a panacea, heroicly, and on every occasion, was hard to escape from. Doctors, as a class, are conservative, and only by slow degrees change from the fashion of their fathers.

Thirty years ago it had been demonstrated that mercury did not necessarily affect the liver and that the continued and indiscriminate use was productive of the greatest injury, yet to this day there are those who cling to it as a sheet-anchor.

Its discovered power over germs has given a new impetus to its application, and made it something of the fashion now.

It was called an *alterative*—a term of vague meaning; it implied a changing of the secretions and a renovating of the tissue in some unknown manner; certain diseases were influenced beneficially, therefore, every one must be dominated by it. As we understand it now, it destroys germs and also all living tissue. At present, few of us own to much use of the drug, but none of us would have it stricken from our supply table. It is yet indispensable in syphilis and some kindred diseases, and in many places as a germ destroyer. We do not use calomel as a cathartic, or a sedative, or a placebo, as they formerly did. We have a wholesome fear of its destructive effect. Other remedies in most instances take its place.

For Opium we have no substitute. The old professor had mastered its use and his greatest triumph was from its application. He quoted with appreciation the words of Sydenham: "Without opium the healing art would cease to exist and by its help a skillful physician is enabled to perform cures that seem almost miraculous." It is one of the oldest of remedies. The ancient Egyptians used it and gave it name and all the generations since have taken it to ease their pains and soothe their distresses; it is a reliever of pain of every kind. It does more—in all our list of medicines it is the most curative. Not a temporary relief as many suppose but a positive cure for a large number of diseases. Many lose sight of this; it must be used with knowledge and judgement. We can account for the action of mercury in its power over living cells, but of opium we only know of its efficacy by observing its action where taken into the system. It relieves the most intense pain in whatever part without deranging or benumbing

* Read before the Clinton County Medical Society, 1893,

the rest of the body. After performing its office it is eliminated and leaves no trace behind. Other drugs stupify the brain, thus rendering the body insensible; opium besides quieting the throbbing nerve renders the brain more active. A concretion from the gall bladder tries to push its way through the duct. It is grasped spasmodically, putting the whole body into the most excruciating agony, agony so intense as to sometimes stop the whole vital machine. A few particles of a salt of opium introduced into the circulation, in a few seconds tranquilizes the pain as if by magic; the torment is over, the resisting duct relaxes, the obstruction passes and the current of life resumes its course as if nothing had happened.

The bowels have become irritable from poison or injury, inflammation has extended to the peritoneal covering, fever runs high, pain is intolerable. In earlier times death was almost certain, recovery was the exception. Blood letting, blisters, drastic purgatives with the indispensible calomel, were the remedies. Purgatives were of no avail. Mercury was no alterative.

The young doctor observed that relief and recovery sometimes followed the use of calomel and opium; he conjectured that it was the opium and proceeded to verify his conjecture. Some desperate cases were placed at his disposal and with careful assistants he pushed his remedy to its fullest limit. He held his patient under its influence until the disease subsided. He achieved a triumph in medicine that gave him a world-wide reputation and a desperate disease was mastered.

Not only in this form of inflammation, but in many others was its efficiency determined. It still retains its place in peritonitis; not even modern surgery has displaced it. It holds pain in abeyance, while the circulation resumes its course and the natural forces come back to their accustomed channels. It acts in lower degree when it quiets the minor frets of the body and leaves the mind free; pushed further, and it brings happy dreams. It is a seductive drug and becomes a vice that never releases its victim; yet, it may not shorten life or destroy the intellect of its votaries.

I need not give a dissertation on the use of opium. There are numerous and excellent ones, but they are not studied by the many, who failing to apply the remedy skillfully, reject it or speak ill of it. It passes for a temporizer, a delusion, a transient refuge while other remedies take effect, a cover for ignorance. It may be all of these in the hands of a bungler. In the hands of a master it is neither; it is the curative drug over all in the materia medica. I am ready to endorse Sydenham's eulogy of it: "Without it the healing art would cease to exist." The physician who does not master its use is not a skillful one, or a master of his profession.

Of Antimony much can be said, though my younger brethren have almost lost sight of it. The elder physicians depended on it for many purposes as their most reliable remedy. They ascribed great power to it over inflammation, and "over the formation and exudation of lymph," the significance of which we have almost forgotten. It is a slow but certain emetic, relaxing the whole system, reducing the heart's action and checking fever. Older people can remember when the glass with sixteen spoonfuls of water, each representing the sixteenth of a grain of "tartar emetic," was the invariable medicine prescribed for fevers, colds or any other disease, and the nausea and sweat that resulted. In pneumonia it followed after venesection. When that went out of use it still held its place, and now in many respects is preferable to aconite, veratrum or any of that class for the disease. In looking over Prof. Wood's Therapeutics, published in 1856, we find thirty pages devoted to Antimony. Used "to reduce arterial excitement, to promote absorption of effused fluids, to subdue inflammation and inflammatory states, in *bronchitis*, *pneumonia*, *peritonitis*, *hepatitis*, *nephritis* and the earlier stages of *rheumatism*, in *hysteria*, *cerebral excitement and delirium tremens*." When a dislocation of the thigh required the rack and the pulleys, relaxation of all the muscles was produced by a full dose of Ant.-Potas.-Tart. It is an older and undoubtedly as efficient a remedy for alcoholism as the Keeley cure. We are now using many substitutes for it with indifferent success. Without doubt, the next generation will rediscover its virtues, as many had done before Basil Valentine brought it into notice in the fifteenth century. Probably his competitors named it *antimony* or *antimonk*, from the destruction they averred it wrought among his brethren.

Quinine, or the cinchona salts that it

stands for, found its place when first introduced, and has maintained its ground to the present without displacement. It is the antidote for malaria, or that germ or poison that produces the specific fever called intermittent. It brought relief to what was considered an incurable disease of very wide prevalence. It rendered life endurable in many lands and made many countries habitable that before were dangerous to approach.

Boerhaave and his contemporaries of the lowlands, retired to the mountains at certain seasons to enjoy or endure their annual 'ague,' not to escape it, for it was in the system for all time ready to break out on any occasion. Now this is obviated; we stop the disease and relieve the system of it in any locality. Its range of action is limited; it is specific in the one disease and its complications. We have attempted to enlarge its scope; only casual observation will convince us that we have not succeeded.

In malarial lands the poison infiltrates the system and is ready to assert itself whenever fatigue or disease enfeebles or lowers vitality. Quinine removes the malarial factor and other remedies must be used for the other disorders. It is doubtful if it is beneficial as a bitter tonic, as it arrests digestion. Its beneficence is shown in the western country where ounces and pounds are used with no discrimination, a mere placebo; because necessary in some cases it is given in all, because it is at hand. No harmful results follow this extravagant use. It seldom leaves any trace after it. No substitute for it has yet been found. Its properties were only partially known to the old professor, who could not be reconciled to the heroic doses his western brethren were prescribing. It was a puzzle when a western student told him he had cured the intractable diarrhœa of the servant girl at his boarding-house by repeated five-grain doses of quinine. In non-malarial countries quinine is of little value.

Iron is one of the oldest remedies on record for its tonic or restorative effect. We know of its essential place in the corpuscles of the blood. Thirty years ago a wave or craze had set in in its favor which has in a measure subsided. It holds its place still, but the system sometimes fails to receive it and we substitute other tonics in its place. There must be, however, the due amount of iron in the blood, and when deficient we must resort to it in some of its forms as a restorative.

The Professor did not say that he confined himself to these five remedies in his practice, but that he might. He belonged to the incoming new school of practitioners that discarded the heroic practice of the old, and were denominated 'nihilist,' while at this time we would call this newer practice extravagant. "If I was very ill," said Dr. Squibb, of Brooklyn, to me about that period, "I would send for some of those big doctors of New York to diagnose my case and then call in some country practitioner to give me medicine." He probably thinks differently now.

The practice of medicine has made an immense stride in a quarter of a century. Many valuable medicines have been added to our list, but the greatest gain has been in the way of preventive remedies and measures. The list of medicines used by any of us now is very brief, ten or twelve will cover it. Not that we are not posted as to the others, but of all of the hundreds added, only three or four are of specific value. The rest are only variations of the old effects or shaded ones. We should not fail in our knowledge of them, but with all our knowledge we are limited to every small number of modifications of vital forces that are salutary. With skill a few remedies will produce all of them, the five named or even less. Water may be so manipulated as to accomplish all, or electricity, or the movement cure; they may be most serviceable in some cases, but in most they are cumbersome and only illustrate the ingenuity of the operator. Our progress in science has restricted rather than increased our use of drugs, the greater number are only auxiliaries or placebœs of not much value except for the period when they are in fashion. There are enthusiasts who are ever seeking novelties; they have yet a hope of finding the elixir of life and occasionally bring us something useful—in a generation some notably ones, only a few.

I have been a teacher and in active practice for the last twenty-five years, and as a close student of medicine endeavored to keep myself in touch with all its literature. I avail myself of all I deem of value of the latest arrivals, yet with all I am ready to endorse the saying of my old teacher, with five remedies I will combat all the diseases that arise in ordinary practice.

# COMMUNICATIONS.

## THE FIRST AMERICAN SYMPHYSEOTOMY.*

ROBERT P. HARRIS, M. D., PHILADELPHIA.

Until late in October last we were under the impression that the first symphyseotomy on this side of the Atlantic was performed by Professor Charles Jewett, of Brooklyn, on September 30, 1892, but it was then discovered that the credit belonged to Dr. William Thomas Coggin, now of Athens, Georgia, who operated in Freedman, Northeast Alabama, on March 12, 1892, more than six months before, with entire success; his residence at that time being in Keener, in the same mining region. Learning of Dr. Coggin's case at the time indicated, I opened a correspondence with him at once; have had ten letters from him since November 1, 1893; have secured a report of his operation for the *American Journal of Obstetrics*, for which it is now in press; and am here prepared to do him credit for the initial operation in this hemisphere. I should feel inclined to censure him for withholding his case from the profession for so long a period, but for the fact, shown in his first letter to me (November 2, 1893), that he was under an impression that as many as five operations had antedated his in this country. Had he known, as he does now, that he was the pioneer operator, we should, no doubt, have had an early report, and he would have been of influence in introducing the scheme to the favorable acceptance of American obstetricians.

The record of Dr. Coggin's case shows that Drs. Pinard and Varnier, of Paris, had nothing whatever to do with inducing him to perform the operation, thirty-six days after the initial trial of the former, as he had not heard of Pinard's case, or of their advocacy of the method. He was in Heidelberg in 1890, where he heard, from an Italian physician, an account of the remarkable successes under the operation in Naples, and received one of Professor Morisani's papers on the subject. He then decided to prefer symphyseotomy to craniotomy, whenever a case should come under his care in which one or the other should be presented as the alternative; and it was thus that he became the second to perform the operation after its exit from Italy. Had he been in a large city, he might have met with a proper subject much sooner, and have antedated Professor Pinard in his work, as he had in his acceptance of the applicability of the method. Dr. Coggin was a graduate in medicine of eight years' standing when he went to Germany, and prepared by experience to value a plan of obstetrics that opened to him a way of avoiding the objectionable one of craniotomy.

It is well know that no one in Europe, except in Italy, performed a symphyseotomy from 1865 to 1892, although from 1886 to 1892 there was enough in the measure of success attained to warrant its introduction into other countries. A mortality of 5½ per cent., we should suppose, would have secured imitators at a much earlier period, but for the fact that the Italians made but little boast of their work, and appeared to be indifferent upon the question of breaking up the old and deep-seated prejudice against the operation. Although aseptic and antiseptic measures had effected a revolution in results, it was not until a long record of successful cases had been collectively reported that the opposition of a century was made to give way. Having been in correspondence with the active advocates of symphyseotomy since the year 1882, I can understand the effect of the revelation of results that was made to certain Parisian obstetrical writers and observers, in Naples and Paris, during the winter of 1891-92. By that time there was such an array of facts in favor of the operation that it was only requisite to make them known to excite attention; for up to January 1, 1892, there had been in the preceding seven years thirty-seven Italian operations, with two women and three children lost. These cases were in order Nos. 11 and 24; the first of which had been in labor ninety-six hours, and the second, several days; case 11 died of septicæmia, and case 24 of metro-peritonitis.

Dr. Coggin operated upon the wife of a miner, a tall and apparently well-made

* Read before the Philadelphia Obstetrical Society, January 4, 1894.

primipara, 23 years old, and five feet and seven inches high, who had been fifteen and a half hours in labor when he was called in. He tried to deliver by the forceps, but found the pelvis too much contracted to admit the passage of the instrument, being of the *justo minor* type, and computed to be one-third smaller than the average. He opened the symphysis after sixteen hours' labor; applied the forceps; and in delivering the fœtus, which proved to be a male of eleven and three-quarters pounds' weight, noted that the pubic bones became separated two and three-quarters inches. There was no injury produced by the extraction of the child, either to the sacro iliac synchondrosis or to the soft parts.

Under a proper restraining apparatus the pubes readily united; there was no lameness, and the boy did well, as his unusually large size now indicates. There have now been thirty-five operations in the United States, and this woman was among the earliest to be operated upon, and bore the heaviest child but one of the thirty-five, the highest in weight being one of twelve pounds. Of the children, twenty-four were males and eleven females, and the average weight of thirty-three of them was eight pounds. This average is the best possible indication that, in our country at least, the minimum conjugate should be fixed for fœtal safety at two and three-quarters inches, or seventy millimetres.

As promptness in action is a very important element of success in symphyseotomy, we are surprised that there have been only four women lost out of the thirty-five cases, when we consider the fact that short labors have been the exception. As we have secured a record in hours of the duration of labor in the thirty-five cases, we are enabled to present the following analysis: Labor induced in 2 cases; labor before operation, of 6 hours or less, 1; 7 to 12 hours, 5; 13 to 24 hours, 15; 25 to 36 hours, 2; 37 to 50 hours, 6; 51 to 62 hours, 1; 63 to 76 hours, 2; and 89 hours, 1. The four fatal cases were in labor respectively 16, 20, 35 and 72 hours. Of the last 19 cases 1 woman and 5 children were lost.

It is of interest to note the order and date of introduction of the operation into the several countries since its exit from Italy.

The record of the year 1892 has been carefully collected by Dr. Franz I Neugebauer, of Warsaw; Professor Charpentier, of Paris; Dr. Francesco Caruso, of Naples; and the writer, under a reciprocal arrangement, whereby both published and unpublished cases have been recorded, and we have found 81, with 10 deaths and 24 children lost; France had 37 operations, with 6 deaths; Germany 11, with 2 deaths; Austra 6, with 1 death; Italy 9 and the United States 8, with no deaths; Russia 4, with 1 death; and there was 1 each in Brazil, Ireland, Switzerland, Holland, Canada and India, with 1 death, in the Holland case. Under the first thirty-one operations of the year, there were three women lost. In the first six months of 1893, there were more operations than in the whole of 1892, and the record of the year will probably reach two hundred, or more than the Cæsarean and Porro-Cæsarean cases of the world together.

It is worthy of note that France had forty-three operations, and had tested antiseptic symphyseotomy during a year before England, the twelfth country to follow the teachings of Italy, and her first operation; and, although this was entirely successful, others do not appear inclined

| No | Country. | Locality. | Operator. | Date of Introduction. | Result to Woman. | Result to Child. |
|---|---|---|---|---|---|---|
| 1 | France. | Paris. | Prof. Adolphe Pinard. | February 4, 1892. | Recovered. | Died. |
| 2 | United States. | Freedman, Ala. | Dr. Wm. Thos. Coggin. | March 12, 1892. | " | Lived. |
| 3 | Germany. | Strassburg. | Prof. Wilhelm A. Freund. | April 29, 1892. | " | " |
| 4 | Austria. | Cracow. | Dr. W. Harajiewicz. | August 4, 1892. | " | Died. |
| 5 | Russia. | Helsingfors. | Dr. Adolphe Törngren. | September 5, 1892. | Died. | Lived. |
| 6 | Brazil. | Rio de Janeiro. | Dr. Rodrigues dos Santos. | November 11, 1892. | Recovered. | " |
| 7 | Ireland. | Dublin. | Dr. William J. Smyly. | November 23, 1892. | " | " |
| 8 | Switzerland. | Basle. | Prof. H. J. Fehling. | November 25, 1892. | " | " |
| 9 | Holland. | Leyden. | Prof. Hector Treub. | December 2, 1892. | Died. | " |
| 10 | Canada. | Montreal. | Dr. J. A. Springle. | December 5, 1892 | Recovered. | " |
| 11 | India. | Bombay. | Surg.-Maj. H. P. Dimmock. | December 22, 1892. | " | Died. |
| 12 | England. | London. | Dr. Arthur H. N. Lewers. | February 12, 1893. | " | Lived. |

to repeat it. Old obstetrical writers in England are afraid of the Cæsarean operation, and do not appear to realize how much its mortality has been reduced, are strongly wedded to craniotomy, and cannot overcome their educated prejudices against symphyseotomy, the result of a century of training. Her younger obstetricians may in time learn, as we are doing, the value of the opeartion, and give it a fair, honest trial; but the medical profession is very slow in England in making advances; much more so than in her provinces, Canada, India and Australia.

There is much of a fallaby in calculating the risks of symphyseotomy by an average of results, taking all the cases together, good and bad. France twenty-five, and six out of her second lost three women out of her first twenty-five, a change from 12 to 24 per cent. Experience should have secured better results; but experience is largely individual, and properly refers to a repetition of the same operation by the same surgeon, as is very well demonstrated by the tables of ovarian exsection. In symphyseotomy the object should be to deliver the woman of a living child, and to save the lives of both; and anything that comes short of this is to that degree a failure. Another object to be considered is the avoidance of injuries to the woman in the opening of her pubes and the forcible delivery of her child. Haste has in it more of an element of risk of injury in the delivery than wisely-considered delay has.

Each case must be considered by itself in making a prognosis; the woman may have been a long time in labor; she may have a minimum cojugate, a small vagina and a large fœtus; the child may be barely alive or possibly dead, and the woman in a state of much exhaustion. What we call *good* cases generally recover; some *bad* ones, and even *very bad* ones, may do this, but they are to be regarded as exceptional; *extremely* bad ones rarely belie the prognosis.

Symphyseotomy in to many cases belongs to the surgery of emergency, and has to be classified as such. Where the subject is under observation before labor, and the size of the pelvis is tested by pelvimetry, rather than by a trial under the forceps, she will almost always make a recovery, provided she is not injured by a hurried delivery and has not had a hemorrhage produced by incision or laceration.

There is also a fallacy in calcuating the proportion of fœtal deaths by the number lost in a hundred cases under all operators. Where the pelvis is a fraction too small for the passage of the fœtal head, and the woman is operated upon early, she and the child should be saved; but where the disproportion of size between head and pelvic calibre is very marked, there is danger that the child may be lost. Under the eighty-one operations of 1892, there were twenty-four children lost, as follows: Still-born, ten; delivered in a dying state, three; premature and lived three days, one; and died within three days after delivery, ten. An early delivery should have reduced the deaths one-half.

The question is often asked me in letters, what is the death-rate under symphyseotomy for the women and the children? We cannot estimate what should be the prospective risk under the operation, as we have already shown, for so much depends upon varying conditions which may be favorable or the reverse.

Recent experience has shown conclusively that some of the old objections to the operation have been removed under antiseptic surgery. Failure of the pubic symphysis to unite, and lameness produced thereby, are no longer tenable objections. Injuries to the sacro-iliac synchondroses are not recorded in connection with any recent sections in Europe or America, and lacerations of the soft parts, which should seldom occur, can be treated so as to restore them to their integrity and avoid septic infection. The symphyseotomy of to day is a much-more innocent operation than that of a century ago; and we see no objection to using it as a substitute for craniotomy when the case is in skilled hands.

As far as ascertained, there were twenty-seven symphyseotomies in the United States in 1893, and there have been forty operations in North and South America, with four women and nine children lost, a maternal mortality of ten-per-cent. There have been twelve operations in Philadelphia, or one-third of those in the United States, all performed by members of this society. The operation has been performed in ten States and by twenty-six opeartors. Twenty-eight of the cases were in our large cities.

# THE ETIOLOGY OF THE DISEASES PECULIAR TO WOMEN.*

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Although morbid conditions may develop in connection with the genital system of the woman at any time of her existence intervening between "the cradle and the grave," it is beyond question true that there are in her life four great climacteric periods, in connection with which the great bulk of the diseased states to which she is liable develop; in which I should venture, at a rough estimate, to assume that nearly eight-tenths of all of these conditions take their rise. These climacterics may thus be presented at a glance:

1. Puberty, marked by progressive metamorphosis of the ovaries and resulting ovulation and menstruation.
2. Marriage.
3. Child-bearing.
4. The menopause, or change of life, marked by retrograde metamorphosis of the ovaries and resulting cessation of ovulation and menstruation.

*First climacteric.*—It is the ovaries which mark, by their rise to and fall from power, the beinning and the end of woman's functional career. Hippocrates, over two thousand years ago, enunciated the dictum, *propter uterum mulier est.* It was left for our own Peaslee to correct him by changing his formula to *propter ovarian mulier est*, which is the motto which he places at the opening page of his work upon ovarian diseases.

True it is that with ovarian advance and retrogression a simultaneous change occurs in the uterus, but no one will to-day dispute the fact that the first constitutes the cause and the second the result; that the change in the first is the phenomenon and that in the second the epiphenomenon.

From the birth of a female child to its thirteenth year the girl is being prepared by nature for meeting the first great climacteric of her life; and fortunate it is for her if surrounding circumstancee do not interfere with her development, or the ignorance or neglect of her guardians defeat the accomplishment of the result. During the first two-thirds of this time of preparation the uterus, ovaries and adnexæ of the child remain almost entirely dormant. Then, as she advances to the third period, they begin to undergo development, and toward the end of this period the development becomes accentuated, rapid, vigorous and perfect. Then the ovules break away from the Graaffian follolicles, the Fallopian tubes seize them, and pass them onward to the engorged and swoollen uterus, and the great issue which translates the child from girlhood to womanhood has been met.

If the changes preparatory to this event have been properly performed, all goes well; but if from any cause the growing uterus has been checked in its development, been made misshappen so as to resemble a gourd, or been developed fully for half its bulk and made atrophic in the other half; or if the ovaries at the time of call to duty are wholly or in part undeveloped and incapable of performing their functions; or, if the Fallopian tubes or vagina are constricted or impervious, a variety of so-called diseases show themselves, all of which are difficult of cure, and many of which are entirely incurable. If malformed ovaries exist the most agonizing ovarian dysmenorrhœa, amenorrhœa, or emansio mensium, with their sometimes coexisting hysteria, hystero-epilepsy, and even epilepsy, show themselves, and hold out to the poor woman the prospect of a life of invalidism, or at least a lengthy and discouraging course of treatment. Who, in this room does not recall many cases of this kind, which beginning with the very inception of menstural life, have proved most rebellious to currative treatment? If the Fallopian tubes have been strictured by want of development, atrophy, or constriction by out-lying lymph, the girl suffers from severe pain at menstruation, or later in life becomes an invalid on account of sterility or tubal pregnancy. If the vagina is constricted or impervious, retension of blood in it or in the uterus becomes an important factor for evil.

Suddenly, the occurrence of this climacteric, created solely by ovarian dictation, makes an imperious call upon organs

* Read before the New York County Medical Association, December 18, 1893.

hitherto insignificent, and finding them unequal to the demand, a long list of ailments develop themselves as a consequence. On the first day of a month, the girl had been remarked upon as a type of female health, vigor and beauty; on the fifteenth of that same month, the imperfect way in which she has grappled with the functions of her first climacteric have assured her physician that years of invalidism in probability lie before her.

By the patient's friends, even by her physician, if he be a short sighted and superficial observer, the trouble which has occurred is attributed to cold, to fatigue, to mental anxiety, or the like; but "the inexorable logic of events" is destined to belie this hope. If the chief system be dysmenorrhœa, the condition is carefully classified into "neuralgic, ovarian, congestive, or obstructive," and the physician very properly strives to overcome it by using the best efforts to meet a disability, which is commonly due to imperfect performance of those changes which mark the period styled "puberty." If the vagina be constricted or the cervical canal be imperious, they are distended and kept open; if the ovaries are at fault, general treatment by nerve and blood tonics, exercise and calisthenics and local treatment by pelvic massage, and electricity and galvanism, are appealed to, and after a variety of means have been tried in vain, and grave symptoms still exist, the process of ovulation is abolished, and the evil dependent upon it relieved by the humane scientific and entirely defensible operation of removal of the tubes and ovaries.

Fortunate is it that many evils entailed upon the woman by "puberty" are oftentimes susceptible of complete relief. There are, however, some which project their influence into her future life and show themselves after marriage in various ways. For example, a deformed uterus may be the cause of frequent abortions, which no resource of art is capable of preventing; constricted tubes may give rise to hæmatosalpinx and perimetritis the outcome of peri-salpingitis; while obstruction to the transit of the fructified ovum into the uterus commonly gives rise to ectopic gestation.

Surely it is no exaggeration to style this one of woman's great climacterics, one of the periods in her existence which is fraught with the profoundest import for her health, her usefulness and her happiness. If it be true, as I have said, that the period intervening between a girl's birth and her passage into womanhood is the time of preparation for this, her first great climacteric or critical period, much as to her fitness for meeting the issue will depend upon the proper physical development accomplished in this preparatory time, and all those who watch her career—physician, mother, and teacher—should join hands in sending her into the arena as thoroughly prepared as it is possible to make her for her new functions.

*Second Climacteric.*—The first climacteric being passed, the girl emergies from it a young woman, and enters into that period of her life which intervenes between puberty and marriage—speaking approximately, a period extending from the thirteenth to the twentieth year, covering about seven years of her existence. Although during this time falls, muscular efforts, exposure to cold, and pathological changes of tissue may, of course, produce disease, this is, to one who has successfully met the issue of puberty, usually a cycle of health and happiness. Then occurs a second climacteric, which sometimes proves a most baneful one to the healthy and robust woman who enters into it—marriage.

There are three morbid states which now frequently show themselves: First, the development of vaginismus, or spasm at the vaginal outlet; second, specific vaginitis, endometritis, and salpingitis, and third, the manifold evils resulting from the induction of abortion by women who resort to this fatal and criminal practice, not to protect their characters from disgrace, but merely to suit their social convenience, or from dread of the dangers of childbearing.

Of the first and third of these I shall say no more, as the management of the first is quite simple and generally understood; and as a mere mention of the third is all that I deem necessary. Of the second, I shall speak more fully and venture to quote upon it from an address given by me which has already appeared in print.

Until the last twenty years specific urethritis was regarded, in the male, as an affection of the most trivial import, as rapidly passing off, leaving few serious sequelæ, and offering itself as an excellent subject for jest and good-natured badinage.

About two decades ago Dr. Emil Noeggerath published a dissertation upon this affection, which will forever preserve his name in the list of those who have accomplished good for mankind, and give him claim to the title of benefactor of his race. This observer declared, first, that out of growing young men a very large proportion prior to marriage have specific urethritis; second, that this affection very generally causes urethral stricture, behind which a "latent" or low grade urethritis is for many years prolonged; third, that, even as late as a decade after the original disease had apparently passed away, the man may transmit it to a wife whom he takes to himself at that time; and fourth, that the disorder affects, under these circumstances, the ostium vaginæ and urethra, and thence passes up the vagina into the uterus, though the Fallopian tubes, where it creates specific catarrh, and by this disease produces oöphoritis and peritonitis, which becomes chronic, and often end in invalidism and sometimes even in death. For this essay Dr. Noeggerath was assailed by ridicule and by contradiction. The matter has now been weighed in the balance and admitted to its place among the valuable facts of medicine.

My estimate of specific urethritis as a factor in the diseases of women, and I take no peculiar or exaggerated views concerning the matter, will be vouched for by all progressive practitioners of gynecology to-day. Specific vaginitis, transmitted to virtuous women by men who are utterly ignorant of the fact that the sins of their youthful days are at this late period bringing them to judgment, is one the most frequent, most active, and most direful of all the causes of serious pelvic trouble in women—one which meets the gynecologist at every turn, and one which commonly proves incurable except by the dangerous procedure of celiotomy.

Think for a moment of the terrible position in which a high-minded, upright, and pure man finds himself placed without any very grave or unpardonable fault on his part. At the age of nineteen or twenty, while at college, excited by stimulants, urged on by the example of gay companions, and brought under the influence of that fatal trio lauded by the German poet —"Wein, Weib, und Gesang"—the poor lad unthinkingly crosses the Rubicon of virtue! That is all! On the morrow he may put up the prayer, "Oh, give me back yesterday!" But yesterday, with its deeds and its history, is as far beyond our reach as a century ago, and returns at no man's prayer!

Four or five years afterward this youth goes to the marriage-bed, suffering, unknowingly, from a low grade of very slight latent urethritis, the sorrowful memento of that fatal night, which has existed behind an old stricture, and a result is effected for the avoidance of which he would most gladly have given all his earthly possessions.

All this sounds like poetry, not prose; like romance, not cold reality. But there is not a physician in this room who does not know, and who will not at once admit, that every word that I have uttered is beyond all question true, and even free from exaggeration.

I mentioned, in speaking of the grave duties demanded by puberty, that one of the important functions of the physician in regard to the development of the girl during the thirteen years which precede it, is to instruct her and her guardians how to prepare her for the approaching issue. In language no less strong I would here insist upon the physician's duty to instruct men in all stations of life as to the importance of a "clean bill of health" in reference to gonorrhœa, both acute and chronic, before the marriage contract be entered upon.

Until a very late period the plan universally followed has been this: The man about to be married went to his physician, told him the history of a gonorrhœa, and asked if, now that all discharge appeared to have ceased, any danger would attend his consummating the tie. The physician would ask a few questions, examine the virile organ carefully as to discharge, and if the "outside of the platter" appeared clean, gave his consent to the union. The evil which has resulted from this superficial and perfunctory course has been as great as it has been wide-spread. To day the question of stricture, a slight, scarcely perceptible "latent gonorrhœa," with its characteristic "gonococcus," is looked into, and not until all trace of disease is eradicated is permission given for the union. A marital quarantine is as necessary to-day in social life as a national quarantine is for contagious diseases in general.

Few men, however eager for matrimony they may be, would run the great risks attendant upon precipitancy if they only knew of them clearly and positively. In no field of medicine is the old adge, "Prevention is better than cure," more important than in this one. If physicians would do their duty fully in the matter, how many unfortunate women now languishing from "pyo salpinx" would in the next generation be saved!

*Third Climacteric.*—Let us suppose that the girl has passed through puberty and become a wife, and that no evil has thus far befallen her in either of these stadia of her course through life. The probabilities are that within a year or two she will be called upon to face still another climacteric—that of utero gestation and childbearing.

The passage of the human fœtus through the short, mucous-lined canal which leads from the superior through the inferior strait of the pelvis is attended, even in labors apparently normal, by certain traumatisms which have a most disproportionate bearing upon the health of the woman who suffers from them. The reasons for this are not far to seek. Slit the cervix uteri or the perineum freely with a bistoury in a non-pregnant woman, and little, if any, serious injury would result. The parts would cicatrize and nature would prove herself abundantly able to deal with the trouble. But let a laceration of these parts be effected by the child's presenting part during labor, and a series of events takes place which casts its baleful shadow over the future life of the woman. This unquestionable fact is due to two circumstances which render the parturient woman peculiarly vulnerable to traumatism exerted upon the genital tract in any part of its extent. These circumstances are the following: 1. From the moment of fixation of the ovum upon the uterine wall until the end of gestation a rapid hypertrophy of all the sexual organs occurs. The only phenomenon in the physiology of the pregnant woman which is as wonderful as this is that retrograde process of involution which restores these parts to their normal state, so that at the end of eight weeks the immense uterus, the voluminous broad ligaments, the copious vagina, and the distensible perineum return to their lessened state of non-puerperality. 2. Wounds made in the genital tract of a non-puerperal woman are bathed during their repair by a bland mucus which is secreted by the glands of the cervical canal and by the vaginal membrane. Similar injuries inflicted upon the parts of a parturient woman are bathed by the lochial discharge, made up of ichorous material, holding in admixture flaking decidua vera, disintegrating placenta, and decomposing blood, which, even under favorable circumstances, sets up a sapræmia, and, under unfavorable ones, tends to the development of a dangerous septicæmia.

Such wounds are not prone to heal by nature's efforts, often assume bad features, and interfere greatly with that wonderful and subtle process of involution just alluded to. As a consequence an arrest of retrograde metamorphosis often affects vagina, uterus, uterine endometrium, and broad ligaments, and creates a marked disproportion in the normal relations of all the pelvic viscera at the same time that it weakens those supports which formerly sustained them. In this way we often see as direct and remote consequences of laceration of perineum and cervix uteri some or all of this long list of pathological results:

1. The vagina suffering from subinvolution and unsupported by the perineum, begins to undergo prolapse, its posterior and then its anterior wall pressing downward into the vulva.

2. Prolapse of one wall soon deflects a wall of the rectum and that of the other of the bladder, and misdirection of the forces of these viscera add their influence to increasing vaginal prolapse.

3. Traction by vagina, rectum, and bladder soon affect the uterus, and descent of this organ begins to show itself.

4. The uterus is the more prone to descend under traction because involution has been rendered imperfect in it, and its increase of weight and feeble support from subinvoluted broad and round ligaments render it helpless.

5. Menstruation now occurs, and a granula, almost fungoid, condition of the endometrium, existing in consequence of impaired involution, menorrhagia supervenes and adds its depreciation influence to the concatenation of morbid influences which are rendering the condition of the poor woman more and more wretched.

Could such a collection of untoward symptoms be possible from wounds inflicted by bistoury or scissors upon the perineum and cervix of a non-parturient woman? Not at all. Such results can be accounted for only by the interference of these traumatisms with the performance of an important physiological function, upon the fulfilment of which depends a return of every puerperal woman to the domain of health.

To sum up this part of my subject, there can be no doubt of the fact that a large proportion of the diseases peculiar to women are due to injuries inflicted upon the genital tract during labor, and that among them may be numbered, subinvolution of uterus, vagina, and perineum; fungoid endometritis; uterine catarrh; menorrhagia and metrorrhagia; any of the displacements of the uterus; prolapse of bladder, rectum, and vagina; cystitis; and secondary derangement of the blood and the nervous system, which react upon all the organs of the body.

To overcome these pathological results the obstetrician to-day repairs lacerations of cervix and perineum, lessens the volume of uterus and vagina, shortens the round ligaments, and scrapes away the entire lining membrane of the womb. When it becomes the accepted and universal practice to examine for these traumatisms after every labor, and to cure them by surgical means as soon as practicable after delivery, the diminution which will occur in the annual crop of sick women will wonderfully diminish.

Some years ago, in my clinic in the College of Physicians and Surgeons of this city, being desirous of impressing these facts upon the students, I requested them to notice how frequently each patient who appeared before them would refer the cause of her disease to one of the critical periods mentioned, and agreed that we would review the subject at the end of a month. The result served to fix the fact most clearly in their minds by the frequent, indeed almost constant, recurrence of the phrases, "I was well until my periods began;" or, "My disease showed itself soon after marriage;" or, "I have never been in good health since my last labor, or since a miscarriage at such a time." That there were exceptions to this I need not mention, but they only appeared to be sufficiently frequent to prove the rule.

*Fourth Climacteric.*—We come now to the consideration of the menopause, or change of life, which has been from time immemorial known as the technical "climacteric" of woman.

When the far reaching nervous influences exerted by ovulation and menstruation upon the system of the woman, which continue active for thirty-five years of her existence, are borne in mind, one is prepared to expect decided mental and physical manifestations when a sudden cessation of ovular activity occurs about the fiftieth year. And certainly at that time the nervous system of the woman does become especially liable to loss of balance, as demonstrated by hysterical and nervous manifestations, and even by a tendency to melancholia and other psychic derangements, while disorders of the menstrual flow become marked, decided, and troublesome, and serious tissue-changes in the pelvic viscera appear to be especially frequent. While all this is admitted it cannot be denied that too great stress has been laid upon this period of woman's life as a critical epoch, and that many pathological conditions occurring about this time have been credited to it which have had no connection with it at all.

The swing of the mental pendulum in reference to the matter must be carefully supervised as to both its extremes; the gynecologist being careful, on the one hand, to avoid an over-estimate of the importance of this epoch which leades to making it a shield for incapacity or ignorance; and on the other, being wary of an under-estimate, which may cause him to lose the great advantages which may result from a postponement of operative interference until its occurrence be allowed to exert its legitimate beneficial influence. Indeed I feel that I stand upon defensible ground when I assert that the chief significance of the menopause to the gynecologist exists in the fact that it constitutes a haven of rest for the woman from many ailments which are due to menstual disorders and to hypertrophy and hyperplasia of the uterus. It ordinarily puts an end to subinvolution and uterine hyperplasia, to menstrual irregularities, to metrorrhagia, and to uterine myomata. With such certainty can these results be counted upon that operations for such conditions may be held in reserve, in the hope that by this climateric the necessity for them may be avoided.

Some years ago, when the effects of galvanism in the cure of uterine myomata was upon the crest of the gynecological wave, a former pupil of mine, a man of great industry, enthusiasm, and honesty, requested me to read, prior to publication, a report of twelve or fourteen cases of uterine myoma in which small tumors had been completely cured, and large ones greatly benefited and checked in growth, by this, then new, therapeutic resource. It was not a report of his experience with the method, but one embodying his successful cases. Upon a careful analysis I found that all the cases of recovery and amelioration had occurred in women between forty-three and fifty-three years of age, and that each recovery was coincident with cessation of menstrual flow and other signs of the menopause. The pleasure of reading this honest and laborious account of faithful work was never enjoyed except by the writer and myself, for it did not appear in print!

At the time of the menopause, as atrophy of the cervix uteri and atresia of the cervical canal take place, retention of discharges from the endometrium sometimes occurs, constituting hydro-metra, hæmato-metra, pyo-metra, and when decomposition of the arrested fluids supervenes, the rare condition of physo-metra shows itself.

Two forms of senile vaginitis are apt also to develop themselves about this time —adhesive vaginitis, which closes the vaginal canal entirely, and hemorrhagic vaginitis, which I have on several occasions seen mistaken for carcinoma uteri, on account of its causing sanguineous flow in a woman who has for some time ceased menstruating. In this connection this diseased state is of importance, for the patient will always come to the physician in the greatest state of alarm. Fortunate is it that this alarm may be quieted by the promise of complete recovery.

Lastly, at this climacteric procidentia of the atrophic senile uterus is apt to occur from rapid absorption of adipose tissue, in the pelvis, which causes it to descend from want of support, and inflicts upon the woman a disability at the end of her career, and after she has borne triumphantly the burdens of life.

This completes the list of the most important of the pathological conditions which develop in connection with the menopause, the fourth climacteric of woman's life.

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**The First State Hospital for Epileptics.**

Thanksgiving Day was observed with peculiar appropriateness in the little town of Gallipolis, in the southern part of Ohio, for the day marked the opening of the State Hospital for Epileptics, the first of its kind in this country.

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Wounds of the Heart.—It was formerly believed that wounds of the heart were always fatal. Recent investigations, however, show that a fair proportion of these cases is amenable to cure. Dr. Lumniczer has reported five cases of wounds of the heart and pericardium, only one of which terminated fatally, and Dr. Peebles (Omaha Clinic) reports a case of bullet wound of the heart with recovery. Dr. Heine Marks (*Medical Fortnightly*) has treated two cases of stab wounds, in one of which recovery ensued in spite of the fact that examination with the finger revealed the presence of lesions of the diaphragm, pleura, pericardium and apex of the heart. The literature contains records of many similar cases.—*Int'l Jour. of Sur.*

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The Brookyln Polytechnic Institute announces a new four-year's course in Practical Chemistry, under the direction of Professor P. T. Austen, Ph. D., F. C. S., of Rutgers College and Scientific School, New Brunswick, N. J. Professor Austen is especially known to our readers by his valuable work in water analysis and the philosophy of precipitate-filtration. He is a graduate of Berlin, as well as of the regular course in this country.

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Kitasato, Koch's able Japanese pupil, who has gone back home on a snug allowance from his government of $45,000 to get started and $15,000 a year afterwards, is reported to be already treating consumption with remarkable success with tuberculin modified by himself.

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Sugar and the Teeth.—The common experience of decay in teeth from too much candy is explained by a professor of physiology, who is an eminent dentist, on the ground that sugar prevents the proper assimilation of the lime salts, and thus interferes with the nutrition of the teeth and other bony tissues.—*Ex.*

# TRANSLATIONS.*

## TREATMENT OF ADVANCED CARDIAC DROPSY BY THEOBROMINE.

Germaine See at the August meeting of the *Académie de Médecine* (*Le Bull. Médical*, Aug. 2, 1893), offered an interesting review of the rôle played by theobromine in the treatment of cardiac disease. Theobromine is a dimethylxanthine obtained from chocolate; it is also the inferior homologue of caffein, which comes from tea, coffee, maté, and in small quantities from kola nut. Whilst caffein is soluble in sodium benzoate or salicylate, theobromine is absolutely insoluble in these salts. The so-called diuretin is by no means the equivalent of a salicylate of sodium and of theobromine. It is, in fact, nothing else than about 18 grams of theobromine dissolved in about 4 grams of caustic soda, to which is added 16 grams of salicylate of sodium. The presence of the caustic soda in the diuretin suffices to explain the harmful effects of this drug upon the stomach and upon the circulation. Moreover when one employs diuretin he administers double or three times the dose of theobromine.

As a diuretic theobromine is superior to digitalin, strophantin, caffein, milk, lactose and sugar. It acts upon cold-blooded animals more actively than caffein, but without producing the manifestations of excitement of the nervous centres, and without determining poisoning unless given in a dose five or six times stronger than that of caffein. Its diuretic power is established without adding a narcotic to the theobromine to destroy its vaso-motricity as is the case with caffein. It should be prescribed absolutely pure without an auxiliary. This, with a dose of 5 grams of theobromine, a diuretic effect three times more marked than that of caffein may be obtained. The diuresis lasts for twenty hours instead of but six hours as in the case of caffein. It commences in from about three to four hours and reaches its maximum in from one to two days of the theobromine treatment. The caffein diuresis is more prompt but without persistence. It is worth noting that in exciting the secretory system of the kidney, theobromine does not modify the previous condition of the urine; when albumin is present, it is not increased nor diminished in amount; when there is an excess of urea, it remains at the same point. The digestive organs are rarely affected by the drug. It may in large doses produce vomiting and nausea, but all that is necessary then is to subdivide the dose. The nervous system remains intact; there does not follow nervous excitement, insomnia, agitation, somnolence, whatever may be the dose of theobromine administered. As the dropsy disappears under the use of theobromine the respirations become more easy and regular; the dyspnœa ceases and the bronchial râles diminish in number. The circulation is not disturbed as it is by the use of diuretin. It remains as it was before the administration of the theobromine. When the pulse has been accelerated or arhythmic it preserves the same conditions; excessive arterial pressure has never been noted.

*Indications and Contra-indications.* The moment that there is any asystole, a profound lack of compensation, a general anasarca, with ascites or pulmonary edema, the instant that digitalin and strophantin, or the direct renal exciting diuretics, caffein or lactose have failed, then should theobromine be resorted to at once in the usual doses. There do not exist in the diseases of the heart, nor in the hemorrhagic or inflammatory complications which accompany them any contra-indications that do not exist for digitalin and caffein.

*Mode of Administration.* As theobromine is insoluble in all fluids, it must be employed in pastilles or cachets containing a half gram or gram of the substance. The first day 2 grams are given in 2 or 4 cachets, taken with food or milk. The second day, 3 grams; the third day, 4 grams; the fourth day, 5 grams. On the fifth day and for the four following days the treatment should be suspended. Then administer 2 to 3 grams daily for three days; in this way the effect received may be maintained perfectly. There can be no habit produced, nor is there any cumulative action.

—D.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., and M. B. Werner, M. D.

## ECTOPIC GESTATION.

A Martin (*Berl. Klinisch Wochen*, No. 22, 1893) has always held the opinion that owing to pathological changes which had occurred in the tube the ovum was necessarily arrested there, in the above condition was always present and acted as the inciting cause. His opinion has, however changed, and he now believes that the ovum can never find a place for any attachment unless the mucus membrane is healthy.

The pelveo peritonitis, so frequently met with in extra-uterine gestation is regarded by him as a secondary complication, incident to the growth of the ovum.

The cases recorded as primary abdominal pregnancy cannot be positively accepted, there being an absence of the necessary proofs. Martin reports a case observed by him in which an ovum of four months had developed on the fimbria ovarica. Further development would have resulted in the implantation of the placenta on the adjacent peritoneum, giving the impression that it had been from the first a primary abdominal pregnancy, while in reality it was of tubal origin.

The author reports five cases of ectopic gestation—tubo-ovarian—four of these were classified as tubal pregnancy, and one as ovarian. Martin explains his meaning of *ovariallube*: an adhesion of the fimbriated end of the tube to the ovary, just at the site of the recently bursted Graafian follicle. This has been previously described by Buxnier.

M. has operated on 61 cases; of these 20 cannot be classed strictly under the head of tubal pregnancy. The remaining 41 he divided into 3 classes.

I. In 14 cases the ovum was found more or less intact in its sac—there was no blood in the abdominal cavity, the ovum being found in various degrees of maceration or resorption.

II. The second group embraces 9 cases of rupture.

III. The third of 16 cases is classed under the head of tubal abortion (expulsion of the ovum through the physiological opening of the tube.

M. does not agree with Werth and Veit whose theory is that the expulsion of the ovum results from a contraction of the muscular fibres of the tube, but believed that its passage is furthered by the hemorrhage which takes place at the seat of insertion of the ovum. —W.

## ANATOMICAL CONSTRUCTION OF SOME OF THE GRANULAR SWELLINGS OF THE INTEGUMENT.

L. Philippson (*Centralb. f. Allgen. Path. u. Path. Anat.*, IV., 1893) extended his studies to the subject of the modus operandi of infection (if internal or external). His observations chiefly embraced syphilis, leprosy, and tuberculosis; his studies resolved themselves into the following conclusions:

I. By infection externally we have, 1. Syphilitic sclerosis; 2. The superficial Lepra-node (?) found in the papillar layer surrounded by healthy tissues; 3. Superficial Lupus-nodes. These are all new growths, situated superficially, having sharp lines of demarcation, more or less round or concentric in form; the deeper structures are attacked later in the course of the disease.

II. Infection arising through the circulation: 1. Roseola, syphilitic papules; 2. Acute erythematous spots, or papules of lepra; 3. Efflorescense in miliary tuberculosis (?). These new growths at the onset, extend in their development throughout all the layers of the cutis, and follow along the ramifications of the blood vessels.

III. By infection through the lymph channels, 1. ———; 2. Superficial nodes of leprosy developed about the cutis; 3. Miliary lupus originating from deep-seated infections. The new growths of the third group, which may also belong to the syphilitic or leprous type, cannot be distinguished by any regular appearance, and are rather plexiform in character.—W.

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SATURDAY, FEBRUARY 24, 1894.


## EDITORIAL.

### WHAT WE EAT.

If indigestion could be invested with personality, its insidious, untiring, never-ceasing methods of warfare would rank it chief guerilla of the physical department of those Powers of Darkness allied for the destruction of man. In the affairs of humanity unregenerate, indigestion is mixed up more frequently than any other single factor, and further it can disclose more meanness, develop more depravity, inspire more deviltry, and make greater contributions to the sum of human misery. Eager for results and not for reputation, this thing of evil works most effectively, when in combination with grosser evils which can distract the attention and divert the responsibility. The wise man must have overlooked indigestion, when he declared the love of money to be the root of all evil. A commission of modern experts probably, would confirm this decision, but we believe indigestion would receive distinguished mention.

As he progresses in development, man has begun to realize the importance of taking into consideration the influences exerted, and the immediate and remote effects of the abnormal operation of the most important of vital functions. And the variety of phases which indigestion presents is only exceeded by the variety of methods proposed for its cure. The vast majority of so-called cures have one feature in common—inspired of indigestion, they promote the interests of their inspiration.

With the dawning of preventive medicine and sanitary science came new suggestions for eliminating this trouble, and various sophistical methods have, from time to time, been promulgated, which methods in themselves innocuous, have served a good purpose in attracting attention to clues, the development of which has furnished valuable knowledge for the betterment of mankind.

One of the most persistent of these health fads is vegetarianism, a recrudescence of which appears imminent at present.

The vegetarian is a familiar freak, gen-

erally harmless, and the excuses offered for his existence are thrice told tales. We can view his coming and going with equanimity. When he dilates on the horrors of shedding innocent blood for the gratification of unholy appetites, we are indifferent to his kid gloves and leather shoes. When he triumphantly quotes Holy Writ as authority for a comparative test of a vegetable and a mixed diet, and declaims how the young Jewish captives in Babylon lived on pulse and, as a result, for beauty, wisdom and strength far outstripped their companions who were fed from the royal tables, we refrain from seeking an explanation of another event in the same record, wherein monstrous iniquity and blasphemy was divinely punished by restriction to a vegetable diet. Though at first annoyed by a specious exhibit of scientific dilettanteism, we remember his limitations and in silence allow him to relieve his mind.

He explains how mistaken is the idea that heredity or environment exert any influence on the development of an animal, but that food is the determining factor in the evolution of mental as well as physical qualities, and that on diet depends physical symmetry, mental stamina and longevity. He will contrast the forlorn condition of the measly, stray cat, whose carnivorous diet is responsible for its short legs, savage nature and sneaking propensities, with the stately elephant whose diet of herbs has given him huge bulk, great strength and long life.

He assures us that to herbivorous habits are due entirely the excellencies of the mild-eyed ox, and the spirit and strength of the proud horse, and we commend the innate modesty that leads him to omit the addition of the opinionated ass.

When he wanders into the realms of ethnology, we are ready to believe that, mounted upon his hobby, we can see over the head of the flesh-eating Zulu and view the unfortunate effects of a meat diet on the African bushman. We can even select passages from the romances of African explorers which tell the woes of a race of puny dwarfs who are alleged to live by meat alone, and pass over, as flights of fancy, the physical excellencies of the savage cannibals who are neighbors not far distant. We may demur to his claim of recognizing the food habits from the simple appearance of an individual, in spite of the evidence of a diet limited to veal presented by the appearance of the dude.

In short, we submit to his vagaries because we know his intentions are good, and we believe his enthusiasm may aid in arousing attention to an important subject, and thus be useful in securing and circulating knowledge based on ascertained science.

Whether or not, in his pristine innocence, man was an herbivorous animal is of no importance. So far as we have authentic information, man has always been what he now is—omnivorous. The digestive apparatus provided him is so constituted as to require the use of foods of both animal and vegetable origin, in order to maintain a normal physical equilibrium.

The consideration of food in all its phases properly belongs to medicine, and although the subject is but little understood, scientific research has demonstrated fundamental facts sufficient to afford a basis for its intelligent and accurate comprehension. Indeed the question can be reduced almost to the proportions of a mathematical problem.

The subject may be briefly stated in general terms.

Under physical laws, every action of the living animal, from the unconscious performance of vital function to the severest exertion, implies the expenditure of energy. The energy thus expended is derived from the potential energy stored up in the body. Unless the energy used is

replaced, the supply must speedily fail and life cease from exhaustion.

But energy as contained in food is not available until it has been transformed by digestion and assimilation, into the potential energy of the tissues of the body. This transformation requires an expenditure of energy.

It is evident that the proper and healthful diet is the one that economically maintains the normal equilibrium between the energy used and that supplied.

Physiological chemistry has shown that to obtain this necessary energy, the body must be supplied with various inorganic and organic substances, the latter being absolutely essential and presented in three principle classes of compounds, namely: (1) *proteids*, the nitrogen-bearing compounds; (2) *carbohydrates*, and (3) *fats*. The first class, the proteids, are by far the most important to the economy.

These three classes of compounds must bear relatively definite proportions to one another and to the needs of the body. These compounds are found alike in animal and vegetable tissues, but in varying proportions, and in neither animal nor vegetable are they found in the proportions required for use in the body. If they did so appear the typical food would be ready prepared.

In animal food the proportion of the proteids is in excess, while in the vegetable tissue, the carbohydrates are in excess. By a combination of animal and vegetable food stuffs, the proportion of the one to the other may be brought within the limits required by the living being.

This is the barest outline of the factors involved in the determination of proper food for man, and will serve only to hint the principles on which the physician bases his study of food in its relation to man.

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It is estimated that the world's cucumbers are worth $8,000,000 annually to the gardeners who raise them, and twice that sum to the doctors and druggists.—*Ex.*

A Clever Dodge.—The publishers of a German novel recently did a neat thing in the way of advertising. They caused to be inserted in most of the newspapers a notice to the effect that a certain nobleman of wealth and high position, desirous of finding a wife, wanted one who resembled the heroine in the novel named. Thereupon every marriageable woman who saw the notice bought the book in order to see what the heroine was like.—*Tit-Bits.*

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The Doctor Knew.—If some men are sceptical others place an implicit faith in the doctor's prescriptions; and of these was a man in Limerick who went to the undertaker to order a coffin for Pat Connell.

"Dear me," said the undertaker, "is poor Pat dead?"

"No, he's not dead yet," answered the other; "but he'll die to-night, for the doctor says he can't live till morning, and he knows what he gave him.

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A Courtier.—A little eight-year old Irish boy in one of our public schools was reproved by his teacher for some mischief. He was about to deny his fault when she said: "I saw you, Jerry." "Yes," he replied, as quick as a flash, "I tells thim there ain't much you don't see wid thim purty black eyes of yourn." That was the soft answer that turned away wrath, for what lady could resist so graceful a compliment?—*Selected.*

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Dr. Emdee—Your trouble, my dear madam, seems to be with the liver. Mrs. Slimdiet—I don't see how that can be; the boarders don't complain, and I never eat it.—*Brooklyn Life.*

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A Technicality.—"How did Mistah Jackson come out wif 'is trouble wif de deacons?"

"Does you hab ref'rence to de trial dat de hen-house 'currence gave rise to?"

"Da's what I means."

"He's reinstated in membahship, he is."

"Golly! I though hit were a clah case."

"No'n deedy. What dey charged 'im wid wus chickins, an' dey couldn't prove nuffin' but tuh'keys."—*Washington Star.*

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When a man helps his wife with her work she has to drop what she is doing to wait on him.—*Atchison Globe.*

# ABSTRACTS.

## UTERINE MYOMA.

Twelve months ago a lady about forty-four years old came to me for severe uterine hemorrhage. On examination, I found a large uterine myoma—as large as a man's double fists. No benefit was gained from hot douches, ergot, and as much rest as she could take under her circumstances. I used electricity, but no appeciable benefit resulted. At the end of two months' treatment she was worse off than ever. She went into the Woman's Hospital in my service. The examinations *per vaginam* revealed much solid exudate and tenderness in the pelvis. A laparotomy on her brought to light such dense and extensive adhesions that it was deemed unsafe to attempt to remove the uterus or tubes and ovaries. In this case I determined to adopt a new plan of procedure. I first tied both tubes at their junction with the uterus with a No. 14 silk ligature, using a long curved needle with an eye in the end. This ligature would destroy the functions of the tubes forever and stop blood from that direction coming to the uterus. The uterus was very large and set in solid exudates, like a turnip in frozen mud, and it was feared that even after the tubes were ligated and functionless (though not removed) the blood supply was great enough to continue the hemorrhage. So I adopted the plan of ligating the uterine artery for a half or more of its way down the body of the uterus. Two silk ligatures were applied to the uterine artery as it ascends along the body of the uterus.

As the uterine artery ascends along the body of the uterus to meet the ovarian at the junctions of the tube and uterus, it is tortuous and hugs tightly the uterine body; but one can easily push the needle between it and the body of the uterus and thus ligate it. In some of the fibroid tumors the uterine artery along the body of the uterus enlarges and beats with a tremendous force. Now, this heavy throbbing of the artery is what induces one to attempt to arrest its action, for it does seem that if such a torrent of blood is checked the uterus would not be fed so well.

In my case nearly two-thirds of the way down the uterus the artery received ligatures. The abdomen was closed and the lady recovered. To my great astonishment, the uterus had shrunk to about half its original size in three months. Her profuse hemorrhage stopped and she gained flesh rapidly. Six months after, she was well and the uterus had gone down more than half its original size and felt much more normal in size and shape. Then she appeared perfectly well. Since that time I have done the operation once more, but it is too soon to announce any results.

This new method of operating for uterine myoma consists—1. In ligating the ovarian artery with or without tubal and ovarian removal. 2. In ligating the uterine artery which courses along the sides of the body of the uterus for a half or two thirds its length from the fundus to the cervix. The objects is to induce uterine atrophy and avoid the danger of removal of uterine myoma. The mortality of abdominal hysterectomy for uterine myoma is still very high in the most skilled hands and appalling in the hands of amateur operators. In this operation the mortality over tubal removal will scarcely be increased by the additional time and manipulation necessary to ligate the uterine artery coursing along the body of the uterus. I used a well-curved aneurism needle in performing the operation, thus avoiding the sharp-pointed needle, which might lacerate the vein or artery. One can put the finger and thumb on the artery and feel it beat close to the uterus. A glance at the ever-memorable Hyrtl's representation of the uterine circulation will easily show how the operation can be perperformed. If it be found difficult to secure the corporeal uterine artery in an aneurism, a long, sharp, curved handle needle could be employed, which could be pushed through a part of the uterine substance, if required, to be doubly sure. It is a curious feature that uterine myomata seem to have a very feeble vitality, and by a slight change of blood in some other direction a myoma will frequently shrink. If a uterine myoma can be made to shrink

by a simpler operation than abdominal hysterectomy, the woman is saved from considerable danger and the multilating loss of an organ. Sweeping removal of organs is a backward movement in the art of surgery. This operation will not suit all fibroids, but it seems to me to be a distinct addition to the operation of the removal of the apdendages for "bleeding fibroids" given to us by Battey, Tait and Hegar. This operation is entirely original with me, as I have not observed any note on the idea in literature.—F. Byron Robinson, B. S., M. D., in *N. Y. Med. Jour.*

## URIC ACID DIATHESIS.

Vegetable diet decreases the acidity of the urine, and increases the alkalinity of the blood. Fever does the same thing. Suppose then that a person has a large quantity of the urates in his blood, and the alkalinity of the blood was above normal. At such a juncture he is exposed to wet and cold. As a result, he becomes very feverish, and the alkalescence of his blood falls. It can no longer hold in solution the urates it contains. They are precipitated anywhere and everywhere—around the joints, in the muscles, in the pericardium or endocardium, in the cerebral meninges. Thus we have an attack of inflammatory rheumatism in its varied forms. Just think of your cold baths and alkalies! Use both, and presto the reaction of the blood begins to become more alkaline. The uric acid is taken up, gets back into the blood again, and, by free diuresis and diaphoresis, it is washed out of the system.

If a person has a large amount of uric acid stored up in the system and begins the use of alkalies, and puts himself on a vegetable diet, the acid is dissolved and comes into free circulation in the blood. The effect of this is to make the person feel very ill. A large amount of uric acid in the blood deranges the circulation seriously, and gives rise to severe headache and mental depression. This accounts for the violent headaches that so many experience in conneetion with a uric acid wave. The arterioles are contracted, and the circulation through the brain is decidedly deranged. Certain drugs and acid drinks will throw down the uric acid out of the blood; but at the expense of a reoccurrence of the rheumatic pains in the joints.

It is a well-known fact that during fasting the alkalinity of the blood falls very considerably. Any uric acid in the blood would tend to be precipitated. This fact was specially emphasized by Sir W. Roberts, a short time ago. He made it clear that, to those who are subject to renal calculi, the greatest period of danger is toward morning, when the acid wave sets in. To guard against this acid wave and the formation of renal calculi, he urges that the person should live on a non-gouty diet, should take some digestible nourishment a short time before retiring, and some alkali at bed time. For this purpose he recommends a good dose of citrate of potash in a glass of water. All this is thoroughly scientific. The alkali, in these cases may do good or may do no good, just as it is given at the right time or not.

These cases of dead hands, where the circulation is almost arrested in the fingers, due to contraction of the arterioles, are due to the uric acid diathesis. This distressing condition is an ally of gout. The great majority of those intense headaches of the migrainous types are nothing other than one of the protean forms of the same condition.—*Ex.*

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THE next meeting of the American Medical Association will be held at San Francisco, on the first Tuesday in June, 1894, instead of on the first Tuesday in May, in order to permit of a discussion of the Code by the various State Societies that meet just before the meeting of the National Association.

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JUDGE (to witness)—What is your age, senora?

Witness.—I am over twenty.

"You must tell me the exact truth."

"Between twenty and thirty."

"But when will you be thirty?"

"To-morrow my lord."

—*La Union de Valparaiso.*

## TECHNIQUE IN TÆNIA TREATMENT—REPORT OF A REMARKABLE CASE.

C. M. FENN M. D., San Diego, Cal.

In the absence hitherto of any unfailing tænicides or specifics, it may be profitable to inquire if there are any other methods available for the safe and certain expulsion of the various cestodes. Personally, having abandoned the search for such a remedy, for the reason that it might imperil the well-being of host as well as guest, I find that some of the standard tæniafuges, if employed in adequate doses and supplemented by attention to certain details, to be noted farther on, may be made to accomplish all that we desire. For example, during the local prevalence of tape-worms which followed the importation of a measly herd from Mexico, some years ago, I came to use kameela in doses of 8 to 12 grains (℥ii-℥iii), and ethereal extract of male-fern to the extent of 4 to 10 grams (℥i-℥iiss). These apparently large doses, exceeding those recommended by the authorities of that period, were successfully administered and upon the hypothesis that a parasite which merely imbibes its sustenance, having neither mouth or intestine, and suckers for prehension only, must require quantity as well as quality. In the matter of details referred to, jalap was selected for the before and after cathartic, in preference to several others commonly used. For instance, castor oil, so widely commended in such cases, was believed to be deficient as a peristaltic persuader and practically inert in the presence of mucus. Senna is equally insufficient in its action and aloes correspondingly tardy, expending its force on the lower bowel. Jalap, on the contrary, besides having somewhat of an anthelmintic reputation is safe and admirably adapted for children, to whom it may be given clandestinely in gingerbread or cookies. Following the last dose of the purgative it is advisable to employ frequent enemata of cold water, with or without salt or soap. These appear not only to chill the worm but to measurably increase peristalsis.

Of the three species of tæniæ which mature in the human intestine, tænia saginata, tænia solium and *bothrinocephalus latus*, the first is of more frequent occurrence in tropical latitudes like this owing, doubtless, to the greater consumption of beef in comparison with other meats.

That tænia solium (pork-worm), however, is not unknown here may be inferred from the following case which may also be considered a fitting résumé of the foregoing remarks:

A little boy, on his first legs, injured a toe, to which his mother applied a bit of fresh pork. A second application, soon required, was about to disappear as mysteriously as the first when he was detected in the act of eating it. Three or four months later during a convulsive seizure several segments of a tænia solium were expelled. Believing it to be an instance of *post hoc procter hoc*, active measures were then taken to relieve the child of his unwelcome guest, and before reaching his third year he passed through ten severe ordeals, expelling in the aggregate 110 feet* of tape-worm! The first three doses, by homœopathic direction, the parents believe were kousso or kameela in combination with some other drug. At all events, after each attempt the child was "sleepy, feverish and a source of great solicitude for twenty-four hours." A fourth dose by another attendant was known to consist of 15 drops of chloroform and one drop of croton oil! This was followed a few weeks subsequently by an emulsion of creasote. Still later, at the suggestion of friends, two attempts were made with emulsion of pumpkin seeds. In justice to all parties, it is proper to state that in every instance starvation and purgation with castor oil, castoria, etc., were rigidly enforced. This is confirmed by an incident in the history, when the little patient led his only sympathetic relative to the cupboard and with tears running down his cheeks exclaimed: "Grandpa, I'se so hungry! I'se so hungry!" Meanwhile, reports of the case had reached relatives in the East, who immediately sent out a quantity of pelletierine tannate, with assurance of success. Two trials of this specific (?) quickly followed

*Measurements reported by parents.

bringing away a few feet of the worm as other remedies had done. A small dose of the pomegranate alkaloid remained, but in view of previous failures it had almost been decided to await the natural demise, or suicide (?) of the parasite at the end of four or five years.

The tenth and successful assault was reluctantly undertaken by the writer. Though I should have preferred kousso or koussin for a child, the remainder of the pelletierine was given.

Without special restrictions as to diet a full dose of jalap preceded the tæniafuge about twelve hours, and was repeated next day an hour or two after the exhibition of anthelmintic. After thoroughly scotching the parasite, indicated by the appearance of large segments in the dejections, frequent enemata of plain and salt water were employed. Traction upon the worm was interdicted, but rather it was advised to strap the protruding extremity to the nates and continue injections. At a later hour the head intact and *erect* with fifteen feet of the tænia gave assurance of its unconditional surrender after a siege of nearly twelve months.—*J. A. M. A.*

## THE TREATMENT OF UTERINE FIBROIDS.

Dr. Augustin H. Goelet, in a paper read before the New York County Medical Association (*Am. Med. Sur. Bull.*, January 1, 1894), says the important question which arises in dealing with these growths is when is interference demanded, and what treatment is indicated. A careful review of the literature of the subject and the opinions of those who are entitled to be regarded as speaking authoritively leads to the conclusion that the majority do not regard the removal of these tumors indicated unless they give rise to sufficient inconvenience to warrant the risk of the operation and the mutilation which involves; that the mortality attending their removal is still too great, even in the hands of expert operators, to warrant its being lightly undertaken. If then it is possible to relieve symptoms caused by these growths, the actual necessity for operative interference is narrowed down to a very small field.

The writer does not agree with certain ultra-gynecologists that these tumors should all be removed when they are small and cause no inconvenience, but he strongly urges that they should be submitted to treatment in this stage, because treatment yields the best results when the tumor is small and of recent growth. The indication for the different methods usually employed are carefully reviewed; electricity, curettement, hysterectomy, and removal of the appendages.

Of electricity he says that frequently a symptomatic cure is all that may be anticipated. The results that may be obtained by this method are classified as follows:

(1) Cure of coëxisting endometritis.

(2) Loosening of adhesions between contiguous peritoneal surfaces.

(3) Relief of pain and pressure symptoms.

(4) Control of hemorrhage.

(5) Arrest and some retrogression of the growth.

The writer takes a bold stand in favor of vaginal puncture, believing it to be perfectly safe if properly done and strict asepsis is observed; that is if as much care is taken with this as with other grave surgical operations. He believes that more success would have followed the use of this agent if puncture had not been abandoned as a hazardous measure. He believes likewise that it is important to discriminate in the choice of the pole to be employed against growths of different structure, just as important in fact as in dealing with such growths as warts, moles and naevi upon the external surface of the body. That is, that when the structure is hard and fibrous the negative pole should be selected, and that when it is soft or myomatous, the positive.

The writer lays stress upon the fact that both subperitoneal and submucous fibroids, when pedunculated are not amenable to treatment by this agent. He positively declares that though assertions to the contrary have been made in some quarters, the proper use of electricity in these cases

does not complicate a subsequent operation for the removal of the tumor; but on the contrary, its use facilitates the removal of adhesions and produces a marked improvement in the general condition of the patient. In fact he often employs it for improving the local condition and for building up the health of the patient preparatory to an operation. It has been asserted that the symptoms return after discontinuing treatment, but the writer believes that when this occurs it is either due to a mistaken diagnosis or a faulty technique which may be unavoidable.

Curettement he thinks is useful as a preliminary measure, but it does not yield a permanent result. In support of this opinion attention is directed to the fact that the mucous membrane removed by the curette is rapidly reproduced and the same causes for the hemorrhage which previously existed still remain. For the control of hemorrhage, when both these measures fails, he advocates ligation of the uterine arteries *per vaginam*, as suggested by Martin, of Chicago. He expresses no confidence in ergot alone in these cases, but regards it as a useful auxiliary in the treatment of certain submucous and soft interstitial myomata when it is desirable to excite uterine contraction.

Goelet believes that the principle indication for hysterectomy is to be found in large subperitoneal and very large and hard interstitial growths which yield little, if at all, to any form of treatment. In these cases, even if the symptoms are relieved, their size is usually a source of so much inconvenience as to warrant the risk of their removal. This operation would also be indicated where treatment fails to permanently control the symptoms, when the tumor is situated unfavorably for treatment and when complicated by disease of the appendages.

Removal of the appendages for the purpose of inducing an artificial menopause which may exert a favorable influence upon the tumor, is not regarded favorably. In his experience as well as that of others, it is productive of very little good, and he strongly urges that when the abdomen has been opened, one should not stop short of removal of the whole tumor unless it is impossible to separate it from its attachments.

**Logic.**

Naming a horse is sometimes fully as difficult as naming a baby, although the groom of a well-known New-Yorker did not find it so the other day. Mr. Johnson had a valuable horse which he had called Ajax, and only recently was able to buy an excellent mate for it. What to call it was the problem, and in his anxiety to discover just the right name several days went by. At last he went to the stable one day and discovered that his groom had solved the difficulty for him. The word "Ajax" was painted over the stall of the older horse, and over that of the new-comer appeared, in large chalk letters, "Bjax." —From the "Editor's Drawer," in *Harper's Magazine* for February.

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No More Cheap Neckties.—There is a married man in Detroit whose wife has long assumed the privilege of supplying his neckties. Whenever she came across a "your-choice-for-a-quarter" lot she would lay in a big supply, and the poor fellow always appeared in something that never satisfied his fastidious taste and was sure to be a back number. He bore the thing with Job-like patience until the other day, when he found a job lot of old-time spring hats for ladies. He took the whole outfit, and had them delivered at the house. There was blood on the moon and streaming tears for a time, but peace was finally restored and a contract entered into that the husband should select his own toggery and the wife confine herself to purchasing what her individual wardrobe may require.—*Detroit Free Press.*

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The number of medical women in Great Britain is now 186, and of these 20 have become members of the British Medical Association.—*Pub. Opinion.*

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An Irishman in France was challenged by a Frenchman to fight a duel, to which he readily consented, and suggested shillalahs.

"That won't do," said the second. "As the challenged party, you have the right to choose the arms, but chivalry demands that you should decide upon a weapon with which Frenchmen are familiar."

"Is that so?" returned the Irishman. "Then begorra! we'll foight with guillotines."—*Brooklyn Life.*

# SOCIETY REPORTS.

## SECTION ON ORTHOPAEDIC SURGERY OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

*January* 19, 1894.

DR. J. B. ROBERTS showed a case of

TUBERCULOSIS OF THE SPINE,

which had been brought to him two years previously.

This case had been treated for two years for psoas abscess with sinuses in the buttocks. He was brought to me thinking that nothing could be done for the boy, as the sinuses were affected by muscular contraction. I took him to the Woman's hospital, opened the sinuses in the buttock and curetted the psoas abscesses, washing them out with iodoform and oil through a tube. I made a section of the tensor vaginæ femorus, the psoas and iliacus muscles and curetted posteriorly, but I feared to make an open wound on account of infection. I put him to bed with extension applied to both legs, and, as you see, his legs are comparatively straight. This was fifteen months ago. About two months since the sinus was still discharging. I made an open incision and made a section of the psoas muscle. I put him in bed in a plaster jacket. There was some suppuration of the wound and on cutting down upon the sinus I found that the abscess was infected from below. The child now walks about on crutches very well, and I show the case as a good illustration of what can be done by section of the tensor vaginæ muscle.

He wore a jacket during the early part of the treatment. My recollection is that the spine was much distorted and very crooked when he was sent to me. To make the spine solid we applied a jacket to the breast.

My own feeling is that the suppuration has now subsided, but I may be entirely wrong, and I shall be glad to have Dr. Taylor's opinion, and that of the Chair as to the need of further active treatment. I am a little inclined to think that he had better be put to bed again with weight and pulley attachments to his feet, if this will straighten him more.

### DISCUSSION.

DR. H. AUGUSTUS WILSON: I was profoundly impressed with this case, as, when we examined it, it appeared hopeless to attempt to improve it; but it now shows the benefit which can be obtained by prolonged and continuous treatment of some of these cases of chronic ostitis. At the time the exploratory operation took place the sinuses were not suppurating extensively, but a considerable amount of softened bone existed at the upper end. I once saw a case somewhat similar to this, but the disease was of longer duration; it lasted for forty years. When the patient kept his bed the suppuration ceased, but within a week from his going about there would be a reaccumulation of pus. I urged an exploratory incision, and one was made in the lumbar region. The vertebral bodies were solid and firm, but half an inch from the original seat of the disease was a spicula of bone three-quarters of an inch in diameter, blocking the sinus almost completely; this would probably keep open the sinus for years. I washed the sinus with peroxide of hydrogen and absolute closure took place. Removel of the bone combined with rest in bed for three months completely closed the sinus.

DR. T. S. K. MORTON: I would like to ask in regard to fixation of the spine until suppuration ceases; whether it decreases or increases under fixation, and whether such fixation causes harm by atrophy of the muscular structures?

DR. WM. J. TAYLOR; I would like to ask Dr. Roberts if he thinks he would gain anything by further operative procedures, or whether by keeping up continuous extension while the boy is up and about—for instance, with some form of splint (such as Thomas') incorporated in a plaster jacket, making the rod quite strong—he would gain an advantage.

DR. DEFOREST WILLARD: My experience is decidedly that fixation lessens suppuration, and I continue it as long as there is any possibility of the evidence of caries. I usually support the child when it is up during the day, and at night again apply extension without the jacket.

The experience of the chair is that the longer the period of extension, the greater the gain. The cicatrices must be elongated as much as possible, otherwise contraction will occur from the nature of the flexors. Osteotomy may be advisable two or three years later, after the general health has been established. I should hardly think that any further operation, so far as section is concerned, would accomplish much at present. Is not mechanical fixation desirable until

suppuration ceases? Does it not prevent the formation of pus?

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Dr. John B. Roberts read a paper entitled

A CASE OF PRIMARY TUBERCULOSIS OF THE LAMINÆ AND SPINOUS PROCESSES OF THE VERTEBRAL COLUMN.

The great rarity of this condition induces me to report the case and show the specimen. A girl of about ten years, was admitted to the Jewish Hospital in July 1892, stating that three months previously she had fallen down two steps. The exact history was difficult to obtain because of her ignorance of any other tongue than Russian. She became paralyzed in the legs shortly after the slight injury mentioned. It was difficult to determine whether any relation existed between the slight injury and the paraplegia, as one account of the fall seemed to indicate that it was due to heat prostration. When the child was admitted to the hospital there was no marked deformity of the spine. The paralysis of both legs was complete, both of motion and sensation, and bed-sores existed. Subsequently, swelling about the middle of the dorsal region appeared, but it was evident that this was not the ordinary kyphosis of tubercular disease of the vertebral bodies. The swelling was most marked on each side of the median line, being greater on the right than on the left. Believing that the case was one of tuberculosis of the laminæ, and that there was probably an abscess within the spinal canal, I determined to do a laminectomy. An incision was made in the swelling on the right side of the vertebral spines, from which a small amount of cheesy material, some small fragments of bone, and a considerable quantity of fluid blood escaped. The blood was dark in color and seemed to come from an active venous hemorrhage. The swelling on the left side consisted of a mass of tissue infiltrated with tubercular deposit. The patient died on the table from shock and bleeding, though the bleeding seemed to come only from veins and was not excessive, though it was quite free. Before the patient succumbed I had removed two vertebral arches which were so soft that the ordinary scalpel cut through them with ease, except in one place where I used the chisel. The spinal cord was flattened, but I could easily pass my finger into the vertebral canal above and below. This showed there was no pressure, except at the point where was situated the tubercular swelling, and the hæmatoma was apparently due to the opening of the vein by the disease. I removed a section of the spinal column, examination of which, as will be seen by looking at the specimen before you, shows that the tubercular disease was limited to the laminæ and had not attacked the bodies. The primary disease, therefore, is in the posterior arches of the vertebral column, instead of in the bodies, where it usually is found. A pathological examination made by Drs. Coplin and Bevan, proves the destruction of the bone to be due to tuberculosis. The bacillus was found in abundance.

DISCUSSION.

DR. JAMES K. YOUNG: This specimen should not be permitted to pass unnoticed. The position of the disease is certainly a rare one. Tuberculous process of the spinal column usually commences, so far as I am informed, in the bodies of the vertebræ, and in cases where it begins in the laminæ, it is due to traumatism, usually from fracture. But one similar case has come under my individual attention and in this traumatism was an important factor. If the disease had commenced in the posterior part of the body it might have secondarily involved the laminæ, but it usually commences in the anterior part, and this is the reason why the laminæ are so rarely attacked.

DR. H. AUGUSTUS WILSON: I think Dr. Roberts' was very wise in drawing attention to the clinical features of this case. When it was decided to lay open the abscess, the tumor on the right side had all the clinical appearance of being a very soft and fluctuating abscess; whereas the hard tumor was, or rather seemed to be, a mass of tuberculous fibrous tissue. The clinical features made me approve of Dr. Roberts' intention to evacuate the abscess. I was surprised to find when the abscess was opened that it was a blood cyst. This only shows that we cannot be sure of what is under the skin, and it reminds me of a remark of the late Dr. Gross that we can be pretty sure by inspection, but cannot be positive until an incision is made.

DR. WM. J. TAYLOR: I have seen one case of laminectomy which was done for fracture, but so far as I can recollect the laminæ of the 4th, 5th, and 6th were removed at the time of the operation. The man died in twenty-four hours. At the post mortem it was found that although we had removed the 4th, 5th, and 6th, the 3rd was perfectly solid and in good condition, but the second was fractured. This was a case where secondary operation would be justifiable. The man was crushed by falling coal. There was one of the bones in absolutely good condition, but above and below it fracture existed.

DR. DEFOREST WILLARD: I recall a similar case now under my care—a young man from eighteen to twenty years of age. After a slight blow upon the back, he began to have rigidity and presented all the clinical appearances of spinal caries; there was no kyphosis, however, although the disease had

existed for a year. There was a soft prominence between the scapula in the mid-dorsal region from the fourth to the eight, which was very peculiar, and I believed it to be spinal abscess from caries. Instead of a prominence over the spinous processes there was such a depression that I could carry my finger down deeply. I considered this decidedly a case for operative procedure although there was no paraplegia. I laid open the abcess and discharged a pint of pus. At the bottom of this cavity I explored the vertebræ and found two laminæ lying loose, the sixth and seventh. I gnawed away the eight and also the fifth, which was greatly eroded. There was no appearance of disease of the bodies. Suppuration continued for a long time. I operated a second time, four months later, and finding another lamina carious, removed it. The wound is still open, but I have not seen the case for two months. I understand that the young man is still living, but as he has tuberculosis of the lungs it is not probable that he will last long. It was evidently a case of primary tuberculosis of the laminæ and spinous processes. I do not think there was any marked disease of the body unless it has extended. There was no evident pressure upon the cord.

There is one point in the case of Dr. Robert's, which occurred to me; it is in reference to shock. I have never seen a case of laminectomy in which there was not an enormous amount of shock. Some authors say that it is an operation not attended with great danger; but in my experience, it is an exceedingly serious one. The moment that a finger was placed upon the spine, in the case before alluded to, we thought the man would die; respiration was interfered with, and the shock was so evident that we were obliged to use artificial respiration, injections, etc., to keep him alive. In my experience I have found that all manipulations of the spinal column should be avoided. I shall be glad to hear from the other members as to this point.

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TWO CASES OF CONGENITAL HYPERTROPHY.

DR. THOMAS S. K. MORTON made some remarks upon the subject of congenital hypertrophies of the extremities and reported two marked cases of such hypertrophies of the hand.

The first case occurred in a child aged 18 months. The index and middle fingers of the right hand were enormously hypertrophied in all their elements, while the remainder of the hand was normal. Almost no function existed in the affected fingers. Amputation was resorted to, successfully, at the metacarpo-phalangeal articulations. Microscopic examination showed that all elements entering into the diseased fingers were hypertrophied by a fibro-fatty degeneration. The joints were but poorly evolved.

The second case was that of a child 22 months old. Here the hypertrophy involved the entire hand and lower portion of the forearm and was accompanied with venous engorgement and marked varicosity. There was a deep groove at the middle of the forearm, as if the umbilical cord might have been tied about the member. The hypertrophy in this case was limited to the skin and subcutaneous tissues and did not interfere with function markedly. There was no hypertrophy of the bony or cartilaginous elements. Great improvemt had resulted from the application, for months, of twenty per cent of ichthyol in lanolin under considerable bandage pressure and an ultimate cure looked forward to. The varicosity and venous engorgement had largely disappeared already.

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Dr. George Erety Shomaker, read a paper entitled

CONGENITAL HYPERTROPHY, WITH REPORT OF A CASE OF CONGENITAL HYPERTROPHY OF THE FOOT.

with report of a case of congenital hypertrophy of the foot.

In diagnosis care must be taken to separate the condition from atrophy of the corresponding part; from acromegaly; angiose enlargement; myxœdema; various arthropathies and from skin hypertrophies, as sclerodema neonatorum.

The case reported was undoubtedly congenital. The girl was 19 years old. One brother had a supernumerary thumb. She had hypermetropia, internal strabismus, an infantile uterus, very marked hystero-epilepsy with opisthotonos during the convulsions.

The hypertrophy involved the outer two-thirds of the left foot and involved skin, subcutaneous tissue, muscles and bone. Operation by amputating enlarged toes and dissecting away muscle and hypertrophied skin and connective tissue, gave a satisfactory result.

DISCUSSION.

DR. H. AUGUSTUS WILSON; I would like to say in reference to the etiology that the theory of arrested development seems to me to be the most reasonable explanation of all the deformities occurring prior to birth. The musculo-nervous theory is unsatisfactory in that it explains only some of the congenital deformities, and sometimes it will possibly explain the pre-occurrence of an atrophy when there is present, in the same body, some other deformity, for instance, a intra-uterine amputation.

DR. WM. J. TAYLOR: I had a case of peculiar hypertrophy of the foot in a child a year old.

The child was brought to a meeting of the Neurological Society and was seen by Dr. Mills and Dr. Willard. Some discussion arose as to the diagnosis. The whole of the foot was enlarged. The cast exhibited by Dr. Morton brought the case to my mind. In this instance it was the left foot in which two of the toes were much enlarged; also the great toe, but the remaining toes not so much in proportion.

I have not seen the case for many months. In looking over some papers I came across a rude drawing of the foot, as I was unable to obtain a cast or a photograph as the child was so active. I attempted to make a wax impression but even in that I was not successful. I will see the child and if possible bring it here to show it to the members. Nothing was done in the way of treatment on account of the uncertainty of diagnosis.

DR. G. ERETY SHOEMAKER: In regard to the point just raised by Dr. Morton, we are able to say, definitely in some cases, that it is not due simply to pressure; for instance, when one-half the jaw or one-half the face is hypertrophied, or where the outside portion of an extremity is involved, we must look to a central and, in the case of the face, a cerebral origin. Yet this is saying little, as we know nothing of the ultimate processes which result in trophic changes.

An autopsy should be of great interest if brain sections were made. The value of such an investigation would be much greater, however, in the infant than in the adult, because disuse alone of the hypertrophied or atrophied part would, in time, produce secondary degeneration at the corresponding centre, which might be mistaken, in an adult, for congenital defects; while in the case of the infant no such secondary degeneration could have occurred for lack of time.

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IN his last story, Mark Twain tells of a young colored girl who "experienced religion" in a revival. The next day in dusting her master's desk she happened upon a two-dollar bill which had been left there by accident. "Lord-a-massy," she said, as she covered it with a book so as not to be further tempted, "How I wish't that revival nd been put off till to-morrer."—*Exchange.*

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TEACHER.—"Now, Johnny, do you understand thoroughly why I am going to whip you?"

Johnny.—"Yes'm. You're in a bad humor this morning, and you've got to lick some one before you'll feel satisfied."—*Life.*

**Toots From the Ram's Horn.**

The man who lives for himself is engaged in very small business.

There is more life in one-grain of wheat than there is in a bushel of chaff.

The glory of love is that it delights in doing for nothing what others will not do for pay.

It is impossible to travel far with a man who rides a hobby.

We forget the sunlight when we notice the shadow.

Truth never dodges, no matter who shoots.

It won't do any good to paint the pump if there is poison in the water.

A good appetite is no proof of a clear conscience.

Anybody can be good, and yet good for nothing.

A coward is a man who fears to be called one.

A self-made man is a man out of a job.—*Public Opinion.*

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SYNONYMS.—Steal a chicken and you are a thief; steal $1,000 from your employer, and you are an embezzler; steal $5,000 from the Government and you are a defaulter; rob your competitor on the stock exchange of $10,000, and you are a financier; rob him of $100,000 to $500,000, and you are a wizard or a Napoleon of finance; wreck a railroad and gather it in, and you are a "magnate"; wreck a great railroad system and you are a "railroad king"; "conduct a "negotiation" by which a strong nation plunders a weak nation of thousands upon thousands of square miles of territory, and make the weak nation pay millions of money indemnity for the wrong it has suffered, and you are a diplomat. "Truly, "the times are out of joint."—*Religious Herald.*

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"SAY, father," said the small boy, "did Corbett and Mitchell go to school when they were little?"

"Why, I suppose so."

"Well," resumed the thoughtful young man after a pause, "I bet their teachers never had to whip either of them for fighting."—*Washington Star.*

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A Chicago paper heads a leading article, "Thoughts About Money." There is no necessity for reading it. We all have them.—*Indianapolis Journal.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE AMERICAN JOURNAL OF OBSTETRICS for February. Dr. Francis Foerster continues his interesting series of papers on

**Comparative Microscopical Studies of the Ovary,**

this number being devoted to the consideration of "Small Cystic Degeneration of the Ovary." He sums up the results of his researches as follows:

1. Small cysts are of common occurrence, not only in human ovaries, but also in those of the sow, ewe, and the cow.

2. In accord with the researches of Nagel, the author is convinced that the small cysts are original Graafian follicles.

3. In a process not exactly pathological the stratified epithelial lining of the Graafian follicle undergoes peculiar changes leading to its disappearance.

4. The epithelium first breaks up into an indifferent or medullary tissue, and from this arises myxomatous vascularized connective tissue.

5. The type of the newly-formed myxomatous tissue varies in different animals. It may be medullary myxomatous, or myxomatous lymph tissue, or fully developed myxomatous tissue with a well-marked basis substance.

6. The newly-formed myxomatous tissue is always scantily supplied with blood vessels, which probably grow into it from without.

7. The myxomatous lining of the cyst-wall is always well defined toward the outer fibrous coat, the original capsule of the Graafian follicle.

8. The ovule is present at the beginning of the formation of a small cyst; later it probably perishes, owing to the changed environments.

The paper is illustrated with woodcuts of sections of ovaries showing the appearances spoken of by the author in the article.

Dr. Karl Sandberg contributes an article on

**Symphysiotomy,**

reviewing the opinions of the various advocates of the procedure. The literature of the subject has been thoroughly studied by the author and the views of the operators in this country and abroad are carefully set forth. Faulty union of the pubic bones, resulting in impaired locomotion, was one of the great objections to the operation in its early period. Since its revival, and especially during the last six or seven years, failures in this respect are almost unheard of, whether the operator applies bone sutures or only keeps the divided bones in apposition by a firm bandage. The author believes that if the subcutaneous method of operating be chosen, the soft parts should be loosened by the operation from the pelvic walls on both sides far enough to allow sufficient stretch, and thus serious injury to the soft parts will be avoided. As to the mathemetical limits for symphysiotomy, they can be figured out for a child of normal dimensions. As the biparietal axis of the head is 9.5 centimetres, and we can depend on a gain of 2 centimetres by the symphysiotomy and 0.5 centimetre by compression of the head, a conjugata vera of 7 centimetres will be the minimum limit for the operation. The maximum limit, according to most authors, should be placed at a conjugata vera of 9 centimetres for a flattened pelvis and a maximum limit for a generally contracted pelvis of 10 centimetres. The author is of the opinion that symphysiotomy is naturally destined to assume a position between high forceps delivery on the one hand and Cæsarean section on the other, and is a direct competitor with craniotomy and induced premature labor.

Dr. Adolph Rupp discusses

**Aphthæ and Diphtheria.**

"The object of this paper is to call attention to the fact that although most if not all of our text books scarcely comment on the association of aphthæ and diphtheria, these diseases do occur 'side by side' or concurrently; and secondly, although typical manifestations of aphthæ can hardly be mistaken for diphtheria, even after a hurried or superficial examination, in most cases, occasions are not wanting when the mistake may be made by tolerably careful observers; and lastly, when the two diseases co-exist in the same patient, aphthæ may manifest themselves before the symptoms and signs of diphtheria have done so, and thus the benign malady will more or less mask the serious disease."

Dr. G. William Reynolds reports a case of

**Pyometra.**

The patient was fifty three years old and the mother of ten children. The menopause had occured one year previously. There was an increase in size of the abdomen with bearing down pains accompanied by distress in the vagina and rectum, with great vesical irritability. There was a sense of mallaise, attended with slight chills, and more or less pain in the hypogastrium. Temperature on admission to the hospital was 98°, pulse 80 and normal. The tumor was regarded as a fibroid by most of the physicians who saw her. The credit of the correct diagnosis is due to Dr. Senn, who upon digital examination, discovered obscure fluctuation, and suspected, on account of the age of the patient and the history of the case, that there might be pus in the uterus. This suspicion was based largely upon the fact that no trace of cervix or the cervical canal could be found even when searched for by means of a large Sims speclum. The correctness of the diagnosis was proved by the finding of an abund-

ance of pus upon vaginal puncture of the uterus with a small sterilized trocar at a point corresponding with the obliterated cervix. The uterus was incised by means of the thermo-cautery as nearly as possible in the normal situation of the cervix. The thermo-cautery was used to avoid serious hemorrhage and because it would leave the opening less liable to close permanently by cicatricial contraction. More than a quart of pus escaped. After a through irrigation with saturated boric-acid solution, a half-inch fenestrated drainage tube, about six inches in length, was passed into the uterine cavity, which was about ten inches in depth. Iodoform was used freely, the vagina packed with iodoform gauze and the usual external antiseptic dressings applied. The dressings were changed daily and the uterine cavity irrigated with an antiseptic solution. As the uterus contracted the drainage tube was shortened. She left the hospital perfectly well three weeks after the operation. It is probable that this pathological condition began at or about the time of the last confinement, fourteen years previously, at which time occurred a prolapse of the uterus and laceration of the cervix, with ectropion, followed by ulceration, cicatrization, and closure of the cervical canal. After a thorough and exhaustive study of the literature at his command the author has not been able to find a case identical with, or even strongly resembling, this one.

Dr. George Byrd Harrison contributes a paper entitled

**Points in the Etiology and Treatment of Infantile Eczema.**

The anthor believes that unguents are better than lotions in the treatment of the disease and that they must secure exosmose more surely than lotions, even of the specific gravity of the serum. A most important point in connection with constitutional treatment is that the remedies most commonly used (notably arsenic) are cutaneous stimulants, and their doses should be graduated inversely as the degree of cutaneous irritation, or rather inflammation. He believes that viola tricolor, calcium sulphide, rhus toxicodendron, and numberless other agents generally used, are liable to the same rule of exhibition. When the local lesions of eczema exhibit highly inflammatory conditions the most minute doses of these alterative agents are found to have the best effect. In regard to local applications, where inflammatory action is high they should be protective and soothing; on the other hand, when indolent, most stimulating agents and measures may be employed to alter secretion and promote absorption.

Dr. L. H. Dunning described a "Placental Extractor," and Dr. F. Byron Robinson contributes a short letter on "The Functions of the Omentum." He takes exception to Dr. Ross' statement in the December number of the journal that peritonitis does not occur in dogs and horses and concludes from his observations that the omentum in dogs serves the same purpose as in man: to prevent the invasion of infection, to prevent the adhesion of the gut to the abdominal parietes and to facilitate visceral movement.

The remaining papers in this issue are: "Disputed Points in the Surgery and Pathology of Pelvic Disease," by Dr. Joseph Price; "Neurasthenia in Young Women," by Drs. Henry B. Deale and S. S. Adams; and the conclusion of a paper by Dr. Anna M. Galbraith, entitled "Poliomyelitis Anterior Acuta Infantilis."

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REVIEW OF INSANITY AND NERVOUS DISEASES for December, 1893. Dr. Frank Parsons Norbury writes on

**Insanity in its Relation to Life Insurance.**

The author dwells on the necessity of recognizing insanity and kindred affections early in their course; and on the need of greater attention being paid to these subjects in medical schools.

Cases of this class, dying shortly after successfully passing insurance examination, show the careless way in which these examinations are sometimes conducted. The author criticises companies which avoid the results of this neglect by declaring the policy of a suicide void, as suicide may be regarded as pathognomonic of insanity, and deserving the same regard as any other cause of death.

Dr. Horace N. Brown describes a case of

**Delirium Grave,**

Bell's Mania, and gives Osler's definition: "An acute delirium running a rapidly fatal course, with a slight fever, in which post mortem no lesions are found of sufficient gravity to account for the disease."

The patient was a young man, about 24 years old, who had been feeling unwell for three or four days. He had frontal headache, slight epigastric pain, and was lying in bed in a profuse perspiration, with anxious look; pulse of 84, temperature 100.8°, eyes sunken, pupils sowewhat dilated, face pale, and there was a very strong odor from the perspiration. The respiration was about 24, irregular and sighing, and complaint was made of the throat closing, so that he could not swallow. When apparently unobserved he swallowed without much trouble. He slept poorly, and had no movement of the bowels for six days; the colon was loaded with feces. The throat was normal. One grain of calomel at night, followed by a saline in the morning, was ordered and seemed to have relieved all trouble, as the temperature and skin seemed normal. Urine was normal in amount and free from albumen. Physical examination showed nothing abnormal. Still complained of difficulty in breathing and in swallowing.

The author left town the same evening and next morning found the patient dying. His arms were scratched and bleeding, pupils dilated, tongue protruding, and the general condition of cyanosis. Until the previous afternoon there seemed to be improvement; then he seemed greatly excited by the visit of a friend, finally calmed down, but in a few hours became wildly delirious, with marked delusions of grandeur and self-glorification. The

tongue became swollen, the mouth full of ropy mucus, water was called for and swallowed with difficulty. The respiration seemed obstructed. The tongue seemed tremulous, the conjunctivæ injected, and the cornea glassy. The patient dashed himself around regardless of injury, and grasped at his throat as though it were obstructed. His body was covered with a cold perspiration. During the attempts at speech the words were disconnected and irrelevant.

The diagnosis of those who saw the case at this stage was hydrophobia. No history confirmed this, and there was no family history of insanity. At the post-mortem it was not permitted to examine the brain, and the other organs were found in a normal condition.

The most notable characteristics were the resemblance to hydrophobia, the low temperature and the rapid fatality.

In hydrophobia, the premonitory symptoms, anxiety, depression, social aversion, spasm of glottis and larynx would be similar but more marked. In hydrophobia the delirium is intermittent, and instead of being delirium of grandeur is peevish, and the patient appears trying to escape an unknown danger. It is interrupted by convulsive attacks causing dyspnœa, dysphagia, etc., and spasm of the glottis causes moans to sound like the barking of a dog.

Writers on the subject seem to agree that the cause is some poison formed during imperfect digestion. Post mortem the meninges and gray matter show some imflammatory changes.

The author describes the typical disease at length, showing the gradual changes that take place in a case, lasting as they usually do from ten days to three weeks. The one now reported being the only known case lasting less than three days.

The differential diagnosis from acute mania rests mainly in the prodomes of the mania lasting a number of weeks with no perversion of digestion or appetite and an apparent system in the ravings. In acute delirium this is all reversed. The onset is sudden, digestion and appetite completely deranged, and the delirium is without system.

The high temperature, at the onset, in sunstroke distinguishes it, while the condition of urine, heart, pulse, fundus of eye, and the odor of the sweat distinguished uræmia.

In treatment all efforts must be directed to calming and supporting the system. Removal to an asylum, and the use of bromides, chloral and hyoscine are mentioned, different men advising different drugs. Ægotine and digitalis may be called for, to sustain the heart. Fluid foods, either by mouth or rectum, are indispensible.

Death results in eighty per-cent. of cases, and complete recovery, without physical or mental sequels, never occurs.

Dr. Poncet reports a case of "Myxœdema," with great physical, mental, and moral depravity which he relieved by thyroid erethism. He made a median incision in the neck, found a poorly developed thyroid gland, and raised it, scraped it with his finger, and dressed it with iodoform. The good effect was very great, the myxœdema disappearing and the patient becoming "docile, modest, diligent, and trustworthy."

Another article mentions varying degrees of success in operating in various ways on Exopthalmic Goitre, showing that there is some hope of relief, if not of cure, in these cases.

Dr. F. Velten is quoted as claiming potassium iodide to be a specific in epidemic cerebro-spinal meningitis. He administers three to six grammes daily and has used it many times. He thinks it would have the same effect in pneumonia, owing to the similarity of the cocci.

Dr. F. S. Davis advocates instead of venesection in purperal eclampsia the use of one-third grain of morphia, six drops each of alcohol and tincture of veratrum viridi with thirty minims of water. It produces, he says, relaxation, moist skin and slow pulse. Five cases treated recovered, one requiring a second injection.

In the *Deutsch. Med. Wochensch.* is mentioned a case of salivation due to loss by operation, for infiltrating chancroid, of the lower part of the second and third frontal convolutions. This resembles salivation in microcephalia with rudimentary frontal convolutions.

In the same journal it is mentioned that the appearance of herpes labialis seems to show a local infection, and in cases of meningitis seems to exclude tubercle as the cause, even in cases of known tuberculous antecedents.

Paralysis of the laryngeal muscles is mentioned as a sign of great diagnostic value in tabes dorsales, and a laryngoscopic examination, therefore important in making a diagnosis.

Genhardt names tabes dorsalis as a hitherto unmentioned cause of diaphragmatic paralysis. He gives the history of a case.

In the *Chicago Medical Standard* Dr. Lyman writes of the failure to recognize certain marked forms of rheumatism; transient, vagrant, disorders of brief duration occurring in elderly nervous persons of arthritic diathesis.

A universal prickling over the skin may interfere with sleep, and may resemble a flea bite, etc. Irritation of the superficial nerves of the scalp may occur. These attacks rarely last more than one day.

Various sensations may be felt in the fauces, Eustachian tube, tongue, etc. It sometimes resembles genuine neuralgia in intensity, and may be very persistent in those having gout or diabetes, and in obese persons. A paroxysmal cough with headache occurs, but perhaps the most annoying symptom is gastralgia.

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JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

Dr. Charles W. Allen describes a case of

**Gangrene of the Scrotum,**

in a man 34 years of age, a free user of alcohol.

Almost all of the tissue was involved, and sloughed off, leaving the testicles quite exposed and a peculiar brick-red in color; even the tunics of the left testicle were involved and sloughed somewhat.

When first seen, the case had been neglected for eight days, owing to the patient's intoxication. Until the slough came away, hot charcoal poltices sprinkled with iodoform were used. Afterward aristol and traction strips were applied to such remnants of scrotum as were left. The result was a new scrotum, and the discharge of the patient six weeks after admission.

The report shows how much may be accomplished by patient care in a seemingly hopeless case, and the author writes in the hope of preventing castration in such cases, instances of this needless operation having come to his notice. Constitutional treatment does not seem to have been required here.

The cause of the disease was not known; but it may have been infection through a partially healed bubo, or indirect violence from heavy lifting.

Dr. Frank Lydston, treats of

**Hemorrhagic Emissions.**

The author states that although the literature on the subject is scanty, he has been called on, not unfrequently, to treat the trouble. In some cases the bleeding occurred at the time of sexual intercourse, and occasionally reappeared at intervals for days; in other cases it came on with nocturnal emissions.

Several cases are cited and the conditions in each given. There seems to have been prostatitis with seminal vesiculitis, or else urethral congestion due to strictures present in all.

Irrigation of the deep urethra, irrigation of the rectum with hot water, sexual hygiene, and when required, the internal use of bromides, ergot, gelsemium, etc. The strictures were dilated, if necessary cut, and as soon as the parts would bear it, cold sounds were introduced.

Dr. Willard Parker Worster treats chancres by spraying, daily, with about one ounce of 15-volume solution of peroxide of hydrogen, under 60-pound pressure, and dressing with iodol. He claims good results, and absolute painlessness for the method. The pressure of 60 pounds he thinks very important. All instruments, of course, must be non-metallic.

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THE NEW YORK JOURNAL OF GYNECOLOGY AND OBSTETRICS

for February 1891, contains an article by Herman J. Boldt, M. D., on the

**Ligation of the uterine arteries for the cure of Fibro-Myomatous Tumor of the uterus.**

He considers this an operation of much promise and free from danger The credit of this plan of operating is due to an American, Dr. M. B. Dorsett, whose first publication on this subject was in August, 1890. Martin, however, seems to have been the first to put this form of treatment into practice in this country; and his method is to ligate *en masse*. The author reports a case in which the technique of Martin is followed, with this exception, viz., that the cul de sac of Douglas is opened so as to allow the index finger to be used as a guide in ligating the uterine artery. The opening of course is closed when the operation is complete. If after two months there is no amelioration of the symptoms hysterectomy should be resorted to. The author limits the application of the method to tumors which do not reach a size larger than sufficient to extend two or three fingers breadth above the symphysis. Suppurative disease of the amexia is a contra-indication to the operation.

Dr. G. M. Edebohls gives a

**Report of Five Cases of Acute Appendicitis,**

and remarks on two or three features of the cases only. Two of the cases were of acute gangrenous appendicitis with perforation—a class doomed to a rapidly fatal issue by any treatment except the knife, and that promptly resorted to. The only point of technique touched upon was the matter of irrigating the peritoneum. He felt that there was greater danger of spreading the infection by irrigation than by dry cleansing. As to chronic cases he says that the time has come when we shall deal with this class of cases just as we deal with chronic salpingo-oophoritis, i.e., on objective and on subjective indications alone. A feature of special interest is the reciprocal relation existing between the appendix and the right uterine appendage, as illustrated in two of the cases.

All made a good recovery.

The question of

**Early Catharsis After Celiotomy**

is discussed by Joseph Brettaner, M. D. His conclusions are:

1. In the vast majority of our cases of celiotomy it is a matter of absolutely no consequence if the bowels are moved early or not. Our good results depend solely on perfection in the operative technique and asepsis.

2. In those cases in which early attempts to move the bowels have failed, persistent efforts to produce catharsis should not be made, but on the contrary a dose of opium (morphine) is indicated.

3. In those cases in which we have employed iodoform gauze to exclude the field of operation from the general peritoneal cavity, to prevent infections, it is in his opinion decidedly bad practice to attempt early catharsis, but we should rather wait until the sign of the restitution of normal peristalsis has been given—that is the spontaneous escape of gas per rectum.

Dr. Geo. W. Cale contributes an article on

**Celiotomy for Strangulated Ovarian Cysts.**

Among the causes for rotation of the cyst the author states that long pedicle is one of the prime factors. Repeated displacements by passage of feces along the sigmoid flexure was assigned as a cause by Mr. Tait. It is a well known fact that this accident often complicates pregnancy, and especially is it apt to occur after delivery. Slight rotation may give rise to little or no effects; more complete

rotation may cause atrophy, rupture or gangrene of the cyst. Inflammation may also occur. These symptoms are apt to follow sudden twisting. Complete detachment may occur in cases of gradual twisting. These, however, are rare.

The symptoms of strangulated ovarian cyst are sudden and violent pain in the abdomen, vomiting and shock. The tumor may be changed in position, and possibly grow rapidly large. These cases are to be distinguished from ruptured tubal pregnancy, internal strangulation of the bowels, gallstone, colic, perforated appendix, etc. Following is the report of an acute case with operation and recovery.

James A. West, M. D., furnishes an article on

**Pyelitis and Pyonephrosis in Women, with a Report of the Case of Each.**

The cases are of interest because both recovered, and because they represented two different methods of nephrectomy, viz., extra-peritoneal or lumbar nephrectomy and transperitoneal or abdominal nephrectomy. Among the causes the author enumerates pyæmia, renal calculi, tubercular infection, pelvic growth obstructing the ureters, cystitis, which is most important. It is often difficult to determine whether the pathological process begun in the bladder or the kidneys for the symptoms are somewhat similar, and indeed the diseases are generally associated. The cachexia of chronic suppuration, anorexia, nausea and vomiting, temperature of septic absorption and attacks of renal tenesmus may be common to both diseases. In pyelitis pain in the lumbar region is a marked and almost constant symptom. If the disease be due to renal calculus, the attacks of renal tenesmus will be very severe, pain extending down the course of the ureters into the bladder, hip and thigh of the affected side The attack is often ushered in by a well-marked chill, and accompanied by considerable elevation of temperature. Gravel in the urine is not of diagnostic value, nor is the epithelium of import. In the case reported the bladder was thoroughly irrigated, and the urine allowed to collect for a few minutes. A large quantity of pus and epithellum was found. This, coupled with the pain and renal colic in the left side led to the diagnosis of pyelitis. If the disease be far advanced a tumor may be mapped out, the diagram may be rendered certain by catheterization of the ureters by the method recently perfected by Kelley.

The method of catheterization practiced by Bozeman is yet more direct. He makes a large opening in the base of the bladder in the region of the ureter and brings it under direct observation. Through this opening he is able to irrigate the pelvis of the kidney with an antiseptic solution. The opening is useful, also, in cases of cystitis, by affording free and constant drainage from the bladder. In cases where disease of the kidney is not too advanced, it is an ideal method. If in performing nephrotomy the kidney is found to be diseased to such an extent that it may not be restored to usefulness, at a later day nephrectomy may be performed. Nephrectomy is always to be resorted to as a last measure to save life. Following is the report of the two cases.

# PERISCOPE.

## THERAPEUTICS.

### A Simple Remedy for Coryza.

In the *Review Medicale*, the following is given as an excellent remedy for coryza. A ripe lemon is taken and some of its juice is squeezed into the palm of the hand. The juice is then forcibly inhaled up the nostrils. Two or three such inhalations will suffice, it is said, to cure an ordinary cold.

### Nitro-Glycerine in Sciatica.

Dr. Lawrence reports the case of a carpenter, age 52, who suffered several weeks with sciatica. In order to relieve the pain he had become a morphine user and could not abandon the habit. After trying a multitude of drugs he gave him a 1:100 solution of nitro-glycerine, one drop three times a day, gradually increasing the dose to five drops. Relief was almost immediate and in ten days he could resume his work, completely cured. —*Revista de Ciencias Medicas de Barcelona.*

### Diphtheria Conveyed by a Toy.

In a case of Diphtheria occurring in a child, Abel (*Centrallb f. Bakl.*) had an opportunity of examing bacteriologically the article, (a wooden toy) suspect of harboring the contagion. Portions of the article were washed in sterilzed broth, and from this serum and agar tubes were inoculated and guinea pigs injected subcutaneously. The tubes showed in addition to various organisms, bacilli which resembled in all respects those of diphtheria. The animals died with all the symptoms of that disease and diphtheria bacilli were found at the seat of inoculation. This is the first time, as far as Abel is aware that the specific organism has been found in the object suspected of conveying diphtherial contagion. Circumstances proved that the article could have been infected only on two occasions, nine years and six months respectively, before the investigation. A review of published observations on the subject shows that the former is far too long a period for the duration of infection in diphtheria. Especially valuable in this respect is the experience of Norwegian physicians, since in Norway with its scattered population and limited traffic, the sources of error which obtain in more densely populated countries can be in larger measure excluded. Norwegian records bear out the most reliable

observations made elsewhere, in fixing one year as the longest period during which the contagions of diphtheria can exist in fomites. Abel observes that the fact, pointed out by Loeffler and others, that virulent diphtheria bacilli are to be found in the fauces of patients during the first month of convalescence from the disease, points to the possibility of infection of objects sometimes after the subsidence of the actual malady. In conclusion he emphasizes the necessity for thorough disinfection of the patient's secretions and excretions, and of all objects which have come into contact with him.

### Saline Laxative.

Constantin Paul recommends phosphate of sodium as a substitute for sulphate of sodium. He gives it in the form of lemonade. It does not gripe. The following formulæ are used:

℞ Distilled water.....ʒvj
Phosphate of sodium.....ʒvi¼
Essence of citron.....gtt. xx.
Syrup.....ʒij.—M.

℞ Distilled water.....ʒviij
Phosphate of sodium.....ʒvi¼
Essence of citron.....gtt. xxv.
Syrup.....ʒij
Citric acid.....
Bicarbonate of sodium.....āā ʒiss.—M.

An effervescing mixture.—*Le Prog. Med.*

### Ichthyol in Fissure of the Anus.

Dr. A. Van der Willigen, of Rotterdam, has found this remedy very useful in the complaint mentioned, cures being brought about in from eight to ten days. He gives liquid food and small doses of castor-oil during the progress of the treatment.—*Provincial Medical Journal.*

### Acute Coryza.

℞ Camphor.....gr. xx
Cocaine mur.....gr. xv
Bismuthi subnit.....ʒss
M. Sig.: Use as snuff.

—Prof. Waxham, in *Gross Med. Coll. Bull.*

### Cocaine in Small-Pox.

Dr. Samayoa, of Guatemala, after using this alkaloid in several cases of small-pox, states his results as follows:

Cocaine given continuously from the beginning can completely abort the disease.

If given after the eruption has appeared, it will transform confluent or hemorrhagic into discrete forms.

Sometimes when the cocaine is given from the beginning of the disease, the eruption assumes a corneal aspect and the pustules fall very soon.

Cocaine prevents suppuration, hence there is no secondary fever, and no marks remain on the skin.

To obtain these results it is necessary to give cocaine as soon as the initial symptoms appear, *and it must be continued without interruption.*

The best preparation is the hydrochlorate, and should be continued five or six days or even nine if necessary.—*La Escuela de Medicina.*

### Condensed Milk.

In many places, the milk supply is of very doubtful quality. Often it will be found advisable to try condensed milk. Great improvements have been made in methods of condensing. Good condensed milk, says the *Scientific American*, should when poured from a spoon, be glossy, the more glossy the better. It should be ropy or stringy like very heavy syrup.

The color should be that of cream, but the color varies according to the season of the year in which the milk is condensed, the same as milk not condensed varies in color. Milk is more yellow in summer, when cows are on pasture, than in winter, when they are fed on dry hay.

Thickness varies with age. Thickening by age is natural to condensed milk; rapid thickening only proves that the milk is preserved in the best manner, and retains in the highest degree the characteristics of milk in its natural state. The thickest condensed milk, if in sound condition, is the most valuable. There is a degree of thickness, however, that is inconvenient. If condensed milk is so thick that it will not run out when the open can is inverted, it is troublesome to dissolve. If it is not actually hard, very little stirring in the can will render it sufficiently liquid for convenient use.

Condensed milk, if properly done, does not destroy cream globules, but leaves the constituents of milk unaltered and natural. One method, therefore, of determining the relative quality of different samples of condensed milk is to ascertain the amount of butter that can be made from each.

### Dilatation of Cervix for Dysmenorrhœa.

Pond (*Annals of Gynecology and Pediatrics*) considers three classes of dysmenorrhœa according to the etiology.

1. Where the cervix is small and elastic.
2. Where the cervix is long, conical, non-elastic, and cartilaginous.
3. Where there are associated flexures.

In the first variety he recommends the use of a light Palmer dilator, one or more times, without anæsthesia. It should be carried to the full expansion of the blades, and applications made to the canal, or a strip of iodoform gauze introduced. This can be carried out at the office.

For the second condition he recommends the free division of the stricture on two or more sides, from the internal to the external os, with thorough dilatation, and the introduction of a stem to be worn ten to fourteen days or longer, if necessary. Following this the cervix should be dilated once or twice a month to avoid subsequent contraction. Very long cervices require amputation.

In cases of flexion where, at times, it seems impossible to pass the light dilator, the Elliot

repositor should be used, the organ carried into retroflexion, when the dilator can be easily passed beyond the angle of flexure. Should the cervix be dense, a heavier instrument may be used, and if this fail incision and the stem are resorted to.

He reports seven cases illustrative of the application of the treatment in the different conditions, and suggest that dilatation be adapted to the relief of stenosis even in young girls.

### The Management of the Abdominal Incision.

Reed (*American Journal of Obstetrics*, September, 1893), in a paper read before the American Association of Obstetricians and Gynecologists, held in Detroit, June, 1893, referred to the occurrence of suppuration during convalescence, and the subsequent development of ventral hernia. These complications he refers to defective methods in the management of the abdominal incision.

These relate, first, to the preparation of the patient; second, to the formation of the incision; third, to the method of closure; fourth, to the remote or after-treatment of the wound. Defective methods of preparation depend chiefly upon failure to recognize and remove the debris and germ elements from the minute interstices of the integument.

Defective methods in making the incision relate chiefly to failure to recognize the linea alba and to make the incision through it. Defective methods of closure relate chiefly to faulty principles in suturing Defective methods of after-treatment relate chiefly to the application of the tight adhesive strap with pad, firmly compressing the incision. The methods recommended consist in a thorough cleansing of the abdomen by the application of, first, oil, next, ether with some strong alkali, cleansing with clear water, followed by the persistent application for over half an hour preceding the operation of a strong solution of bichloride of mercury. The incision should be made carefully in the median line and through the linea alba. The method of closure recommended is by interrupted suture of silkworm-gut, passed from within outward on both sides entirely through the tissues, but so passed that it enters the peritoneum near the margin of the wound, dips deeply into the median tissue, and is brought out through the integument near the wound margin. By this means all the structures are brought into immediate apposition when the sutures are tightented. They should not be tied tightly and the knot should be on one or the other side of the incision.

The wound should be dressed with aristol or boracic acid, and a bandage carefully applied. When the sutures are removed a firmly-fitting adhesive strap should be applied, which does not exert such pressure as will induce compression of the incision with a subsequent tendency to separation of the internal margin. The advantages of the interrupted suture, as here suggested, consist, first, in the simplicity of application; second, in passing through and anchorage in the muscles; third, the apposition of like tissues to like tissues; fourth, painlessness after operation; fifth, minimum possibility of infection.

## MEDICINE

### Hiccough.

Dr. Carino, of Palermo, found a diagnosis of hereditary syphilis, which in every case has proved correct, on the occurrence of an obstinate hiccough a few hours after birth, lasting from one to three weeks. The hiccough proves obstinate to all the usual remedies, but disappears after the child has been treated with Van Swieten's solution, and the mother has taken large doses of iodide of potash. The author believes that the hiccough depends upon a neuropathic diathesis, to the development of which syphilis contributes.

HIS FIRST CASE.—A young doctor attending his first case of labor was very much frightened when the membranes ruptured and the waters gushed out, and while looking in utter astonishment at the placenta, the husband said:

"Doctor, do you think she will die?"

"Die? Of course she'll die. Don't you see her bladder's busted and her liver dropped out?"—*Hot Springs Medical Journal.*

### Abortive Treatment of Gonorrhœa With Oil of Cinnamon.

J. Chalmers Da Costa urges, first, the thorough cleansing of the urethral canal by injecting or spraying within it the 15-volume solution of hydrogen dioxide, with a caution about permitting it to produce much pain by overdistension. The antiseptic solution is then used, either with the atomizer or by injection. It consists of the oil of cinnamon dissolved in one of the liquid petroleum preparations. The first day the solution is made of one drop to the ounce; the second day, two drops to the ounce; and after that three drops to the ounce.—*Philadelphia Polyclinic.*

### Aural Reflex of Unusual Character Due to Impacted Cerumen.

Dr. Samuel Theobald (Baltimore) related the case of a woman about 42 years of age, the mother of a large family and of a non-nervous temperament, who had suffered for six months with an annoying cough and with spells of inability to swallow food. These symptoms increased in severity, and it was noticed that any manipulation of the right ear brought on the attack. A plug of cerumen, which probably had been forced down upon the tympanic membrane by unsuccessful attempts to remove it, was discovered in the right ear. It was removed by syringing, and all the unpleasant symptoms at once disappeared. Ear-cough is, of course, of not infrequent occurrence, but spells of inability to swallow, due to reflex aural irrita-

tion, are rare. Burnett, in his work upon the ear, states that both Senac and Jissot have described cases of this character.—*Journal of Laryngology*, etc.

### Prolapsed Hemorrhoids.

It may be some satisfaction to the doctor, as well as a great comfort to the patient, to know a comparatively easy method of effecting reduction. This is it: Posture may be important, but the best one is not always required. In moderately severe cases the patient may be on his back with knees drawn up. If the hemorrhoids are very tender from strangulation and manipulation, cocaine should be applied till analgesia is fairly well established. Then the part should be thoroughly lubricated with vaseline, and the tips of three or four fingers of each hand applied to the purple projections. Steady pressure is to be applied, while the patient is ordered to press down as in the defecation of hardened feces. Instinctively, and almost invariably he shrinks and draws away from the pressure on the painful swellings, at the same time puckering the already too contracted anal orifice. But when he is made to comprehend that puckering renders reduction impossible, while resolute and persistent straining down relaxes and opens the orifice and allows the swellings to be forced back into the rectum, often semi-instantaneously, he will govern himself accordingly. Sometimes the performance can be terminated more speedily by having the patient assume a squatting posture, after the preliminaries have been attended to. Then the straining down seems to be more thorough and efficient, and the piles, liberated from constriction, slide homeward with little compulsion.

This is the facile reduction of prolapsed hemorrhoids; and the patient can be taught to accomplish it early and easily without the aid of a physician.—*Ex.*

## SURGERY.

### Pepsin in Surgery.

So many and so brilliant have been the exploits of modern operative surgery that therapeutic agents often of equal importance, though less attractive to the ambitious surgeon, have been greatly overshadowed. It is to awaken the interest of surgeons in this direction that I call attention to the wonderful effect of pepsin as applied to diseased skin or mucous surfaces, and also to the arrest of neoplastic growth, by its dialytic action, though a remarkable elective affinity, being able to attack *formed material* and substances of low vital resistance without doing violence to the surrounding physiological conditions.

My attention was first directed to this in mounting tissues for the microscope, when, if the higher powers were used, there was always more or less interference with the cellular definition, owing to the presence of certain products of retrograde metamorphosis which could not be removed without material chemical injury to the tissue under observation. It was, of course, clear that any agent capable of producing the desired result without change in the normal morphological characteristics of the tissue must accomplish it by dialytic action. This, I found could be practically accomplished by strong, active preparations of pepsin, which completely cleared off the debris of cellular activity without interfering with the structural elements under investigation. However valuable a discovery this was from a histological point of view, there remained to be developed a higher effect, which was destined to place this agent in the foremost rank of surgical therapeutics.

The action of pepsin upon indolent ulcers is too well established and recognized to require any discussion in this connection, but there is an application of this agent which commands the highest attention of surgeons —I refer to its effect upon neoplasms, and mucous lesions of specific character. It is in gonorrhœa, gleet and stricture, that its most decided effects are manifested. There is no disease but gonorrhœa in which the anatomical and physiological relations present just such indications as are fulfilled by the dialytic effect of this ferment. Most of the agents which have a direct currative effect upon a gonorrhœal mucus surface will also excite undue inflammation in the structural element of the physiological tissue, and we are forced to forego entirely their therapeutic use. Most of the unfortunate sequelæ to gonorrhœa owe their origin to the use of remedies that, while they may arrest or destroy the specific morbific agent, leave the normal tissues in a worse condition than would have been the result of the disease itself.

But in Pepsin we have an agent which in its digestive or dialytic action removes everything before it until it comes directly to the cellular structure of the physiological tissue, which, however, from every cell-wall, as it were, cries out, defiantly: "Thus far shalt thou go, and no further." With perfect impunity we can saturate a diseased mucous surface with a solution of pepsin, and remove not only the debris of morbific action; but where, the vital resistance is weakened, as is always the case in inflammation, the cellular activity of the disease itself will be attacked without in the least interferring with physiological conditions—for elective affinity is as unerring as polar attraction.

Of course there is some little difficulty in preparing the pepsin in a remidial way, but the formula which I here give to the profession is the one which will be used in putting up the remedy in a large scale for immediate use of the physician. The formula has been tested thoroughly under every possible condition, with most decided and satisfactory results.

I shall be pleased to give any information to those interested in this matter, if they address me personally at Waukesha, where I am carrying on my investigations with this agent, and I hope soon to be able to give the profession some further developments of which I am now satisfied, but which require further corroboration before offering them to the profession as established facts.

FORMULA OF INJECTION.

℞ Pepsin (pure).....3iic
Ac. boracici.....gr. xx.
Infus. vaccin. macro.....ʒ j (cranberries)
Aq. dest.....ʒ iiij.

M. S. Inject every three hours.

I have given the name of *Gonopepsin* to the above for convenience sake.

## GYNECOLOGY.

### Trendelenburg's Posture.

Dr. H. C. Coe, in the *New York Polyclinic*, calls attention to the danger of secondary hemorrhage following laparotomy with patient in this position. The elevation of the hips determinates the blood toward upper portions of the trunk and oozing from small vessels in broken adhesions does not take place until the patient is again placed in the dorsal position. He cites two cases of celiotomy in which the patients came near bleeding to death from this accident. The abdomen had to be again opened and after much difficulty the hemorrhage was checked It can well be seen that even many small arteries may not bleed while in this position, but when the patient is again returned to the dorsal position much blood may be lost. Aside from this objection the fact that the respiration is seriously impaired by the weight of abdominal viscera on the diaphrgam is another serious objection to the posture. I is true, however, the surgeon has a view of the pelvic viscera with the patient in this position that can not be obtained otherwise, and that the intestines do not get out of the abdomen with the same facility as with the patient in the dorsal posture, but in our judgment this advantage is far outweighed by the dangers cited above.

## ARMY AND NAVY.

U. S. ARMY FROM FEBRUARY 11, 1894, TO FEBRUARY 17, 1894.

A Board of Medical Officers to consist of Colonel Charles H. Allen, Assistant Surgeon, General-Lieutenant Colonel William H. Forwood, Deputy Surgeon General Major Charles Smart, Surgeon; Major Walter Reed, Surgeon.

Capt. James C. Merrill, Assistant Surgeon, is constituted to meet at the Army Medical Museum Building, in this city, on the 12th day of March, 1894, at 10 o'clock A. M., for the examination of candidates for admission to the Medical Corps of the Army.

## NEWS AND MISCELLANY.

### A New Way to Execute Criminals.

A bill has been introduced in the Legislature of Ohio opposing hanging and providing that all murderers sentenced to death shall be put out of the way by means of anesthetics which are to be administered under the supervision of a board of physicians and scientists. The condemned man having been placed in a painless sleep, the scientists are to be permitted to take the top of his skull off and watch the actions of the brain and lay bare his heart and other organs and study life there.

The author of the bill is a physician and argues that its passage would give scientists an opportunity to study the currents of life as they have never been studied before, and would undoubtedly result in the most wonderful discoveries to the benefit of humanity.

### State Medical Examiners.

Governor Pattison appointed the following State Medical Examiners under the act of May 18, 1893, the three schools of medicine being represented.

Allopathic—H. G. McCormick, Williamsport, three years; Henry Beates, Jr., Philadelphia, three years; W. J. R. Kline, Greensburg, three years; A. H. Hulshizer, Philadelphia, two years; N. S. Porter, Pittsburg, two years; J. E. Silliman, Erie, one year; Samuel W. Latta, Philadelphia, one year.

Homœopathic—C. S. Middleton, Philadelphia, three years; Hugh Piteairn, Harrisburg, three years; Isaac G. Smedley, Philadelphia, three years; Edward Cranch, Erie, two years; C. F. Bingamen, Pittsburg, two years; Augustus Korndoerfer, Philadelphia, one year; J. F. Cooper, Allegheny, one year.

Eclectic—H. Yeagley, Lancaster, three years; Augustus Niles, Wellsboro, three years; L. B. Oneale, Mechanicsburg, three years; H. B. Piper, Tyrone, two years; J. R. Borland, Franklin, two years; W. H. Blake, Philadelphia, one year; A. B. Woodward, Tunkhannock, one year.

The act also establishes a Medical Council, consisting of the lieutenant-governor, attorney-general, secretary of internal affairs, superintendent of public instruction, president of the State Board of Health, Presidents of the three boards of examiners appointed to-day. The members of the council receive no salary, except the secretary and treasurer, who will receive not over $500. The council will meet twice a year, and supervise the examinations of the State boards and issue licenses to practice medicine and surgery. The expenses of the Board of Examiners, it is provided, shall be paid from fees, and if any surplus above expenses shall remain at the end of any year, it shall be apportioned among the examiners pro rata, according to the number of candidates examined by each. The first meeting of the Examining Boards will be held on the first Tuesday of April.—*Public Ledger.*

### The Approaching Cholera Conference at Paris.

THE EXTINCTION OF CHOLERA.

M. Hanotaux, Minister Plenipotentiary Director of the Consulates of France, and

delegate of France at the forthcoming International Cholera Conference at Paris, has stated to a representative of the French press, in a published interview, the precise object and anticipated results of this Conference. The Conference, he states, will occupy itself with tracking the cholera to its seat of origin—that is, Asia and India, dealing especially with the Meccan pilgrimage; the principal question laid before the Conference is to find thus "the examination of the Asiatic origin of cholera, and the measures to be taken relating to the defence of Europe against this scourge." Without prejudicing the results, M. Hanotaux has reason to hope that this Sultan and the Czar of Persia will assist in arresting the development of cholera at its Asiatic ports of entry and posts of reinforcement. "The English," he observed, "are especially interested, since they hold both ends of the inlet. and outlet, India and Egypt." M. Hanotaux continues as follows: "The Conference builds largely upon the assistance of Great Britain, for one of the most brilliant European hygienists, Mr. Ernest Hart, has denounced Mecca as a main centre, from which European cholera spreads, in an address of widespread influence. He has pointed out that Hagar's well, where the Mussulman pilgrims wash and drink, is nothing better than sewer water; in one day (June 26, 1893) there were 500 deaths at Mecca from drinking this water. Let the pilgrims die for the glory of Mahommed, that is their affair, but they spread the cholera to the rest of the world, and they must be prevented from making us that present. The Paris Conference will mainly occupy itself with this object; it will not be far from agreeing with the English sanitarian, Mr. Ernest Hart, in saying that the extinction of epidemic cholera in Europe may be secured without great difficulty. There are two ways of attaining this result; to ensure everywhere perfectly pure drinking water, and meantime put an end to the cause of insalubrity of Meccan pilgrims. It will agree with him that 'outside of this all measures are illusionarv; fumigations, railway and frontier quarantine, powderings and antiseptic fluids, are only vain ceremonies, simple sacrifices to popular ignorance, the idolatrous homage which dirt pays to cleanliness. The prime focus of cholera is India; its gates of invasion are the Indian fairs and the Meccan pilgrimage. Mecca is the reinforcing station of cholera between the Gulf of Bengal and Europe; it is there especially that the chief danger lies.''

The measures, therefore, wich the International Conference on Cholera at Paris will be called upon to resolve are, M. Hanotaux announces, those indicated by Mr. Ernest Hart in his address at Edinburgh and in America. "Thus we shall undoubtedly instal medical posts and posts of inspection at two points, which he points out as the most important to be watched—Thor and Camaran. Every ship and every caravan of pilgrims will be accompained by a medical staff furnished with all that is necessaay for the purification and disinfection of the sick. The conference will consider resolutions as to the necessary reorganization of the sanitary service of India, the regulations of the great fairs of that country, the organization (as suggested by Mr. Hart) of a system of inspection of the pilgrims before leaving the Indian ports, and the curatorship of the sacred wells in which the Mussulmans bath and drink at the same time." To carry out this, M. Hanotaux concluded, "will be to win a decisive victory over cholera; such a battle is well worth waging."

The following are the delegates for the Paris Sanitary Conference, which will take place at Paris: For France, MM. Barrere, Hanotaux, Brouardel, Proust, Monod; for Germany, MM. von Schœn and Mordtmann; for Austria-Hungary, Count Kuefsten, Dr. Hagel, Dr. Karlinskii; for the United States, Drs. E. Shakespeare, Stephen Smith, and Preston Bailhache; for Greece, M. Criesis and M. Vafiader; for Italy, The Marquis Malespina and Dr. Pagliani; for Portugal, M. Navarro; for Sweden and Norway, M. Due; for Turkey, Turkan Bey, Nouri Pasha, Bonkowski Pasha, Dr. Hamdy Bey; for Persia, a delegate nominated by the Minister of the Shah, in Paris; for Egypt, Achmet Choukry-Pasha, M. Mieville and Sedky-Pasha.

### Physicians In Japan.

An ex-attache writes: "Perhaps the most charming manner of compensating physicians for their care and attention is that which is customary among the natives of Japan. Physicians do not charge for their services, but on the contrary, decline to name an amount, and protest against any idea of remuneration. Patients, on their side, are too proud to accept such services free, and send to the physician—not as a fee, but more as a friendly gift or token of gratitude—a sum of money, proportionrte to the means of the giver, with some pieces of silk, bronze, or lacquer-work; the idea being that medical attandance is by far too important and elevated a character to be desecrated by barter for filthy lucre." What a pity that our Western civilization, with all its common place vulgarity and lack of delicacy, will not admit of adoption of such a charming method of intercourse between the medical man and his patients.—*The Medical Age.*

### Lead Pencil in Uterus.

A few miles from Albilene, Texas lives a lady who passed a lead pencil, full length, into her womb, and, unable to extract it, sent for Dr. Blakemore, who, after a digital examination, assured her she must be mistaken. In six or eight weeks the doctor was sent for; found patient with a tender, fluctuating, inguinal swelling on one side; opened the abscess, and lo! a lead pencil, the veritable one which, entering at os uteri, had penetrated the uterine wall, broad ligament, and approached just beneath the surface of the skin, to be liberated by the aid of the scalpel.

The woman made a good recovery.—Dr. L. A. Gizzard in *Medical Brief.*

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# ORIGINAL ARTICLES.

## THE LEGAL RESPONSIBILITY OF THE AGED.

J. J. CALDWELL, M. D.,* Baltimore, Md.

History is replete with the failings of old age. The exceptions are rare and stand out like meteors.

"There is a senile dementia, and a form of dementia associated with general paralysis. Dementia also has its degrees and its stages of *forgetfulness*, irrationality, incomprehension, and inappetency. A patient suffering from dementia, as he passes from bad to worse, *first* exhibits want of memory, then *loss* of reasoning power, then inability to comprehend, and lastly, an abolition of the common instincts and of *volition*.—p. 50, *Field's Medico-Legal Guide*.

In the progress of this mental disorder the mind usually dwells only on the past, and the thoughts succeed one another without any obvious bond of association.

Delusions, if they do exist, are only temporary and leave no permanent impression, and for anything recent the mind is exceedingly weak. If it occurs as *acute dementia* in *young people*, it is generally incurable. In old men, in whom it most frequently occurs, it is called *senile dementia*, and indicates the breaking down of the mental powers in advance of bodily decay. The person may become oblivious of names and dates."

Prof. Geo. M. Beard, now deceased, the great neurologist and electrician of New York city, and author of an elaborate work on these subjects, has divided a paper read before the Medico-Legal Society of New York, into three heads, viz:

1st. What is the average effect of old age on the mental faculties? In other words, what is the law of the relation of age to work?

2d. To what extent is the average responsibility of men impaired by the change which the mental faculties undergo in old age?

3d. How shall the effects of age on the mental faculties be best brought to the attention of our Courts of Justice?

These questions have been a life-long study with this scientist, who set about making his investigations without fear or prejudice, and in the full hope that the result of his researches would be made available in deciding the condition of the minds of men past the full maturity of life.

Dr. Beard has deduced these general results from his prolonged investigations, viz:

| | | | | | |
|---|---|---|---|---|---|
| The golden decade is | between | 30 | and | 40 |
| The silver | " | " | 40 | " | 50 |
| The iron | " | " | 50 | " | 60 |
| The tin | " | " | 60 | " | 70 |
| The wooden | " | " | 70 | " | 80 |

He found that seventy per cent. of the work of the world is done before the age of 45. Nearly all the great systems of theology, metaphysics and philosophy are the result of work done between 20 and 50 years of age. And this law holds good in animals and plants as well. Horses live about 25 years, but they are at their best from 8 to 14. Dogs live 9 to 10 years, and are best for hunting purposes from 2 to 6 years. Children born of parents

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healthy in middle life (from 25 to 40 years), are stronger and smarter than those born of parents either younger or older than these extremes; and the same fact applies to the breeding of other animals, as in horses, dogs, and cattle. The hen has her best laying capacity at her third year. She will lay in an average life-time, say nine years, from 500 to 700 eggs. In her first year only 18 eggs; in her second year about 110; in her third 130, the golden period; her ninth year only 10 eggs, if any. In old men the faculties morally deteriorate as do the physical.

This does not necessarily make an old man a bad citizen in the true sense of the term, as of a neighbor or a harm-producing person; but unless sustained by a higher power, he is apt to give a looser rein to his feelings and expressions, to display irritability, less consideration for the feelings of others, and if he has had any variety of brain trouble, this is apt to reflect on his every act.

The diseases to which the brain is liable through a long course of years, are many. Such as blows, destroying the memory of names, dates, locations and events; a bereavement has destroyed the memory of names alone. Millionaires once known for their liberality have grown stingy in old age. Hemorrhage in the brain and the various disorders within the cranial cavity have suddenly or more gradually made the clever foolish, the patient petulent, the hopeful despondent; have caused men, and women too, to change almost *instantaneously* their religious and their political doctrines. When the intellect is impaired by disease of any kind, or by the decay of *age*, men cannot distinguish the true path as of old, even when they desire to do so.

The changes in the brain from old age much resemble a diseased condition, either like the result of hemorrhage from the giving away of the cerebral arteries, from thrombosis, from hardening of the arterial coats, from meningitis, congestion, from anæmia of the brain substance, from nerve tissue decay, and from softening; and death in aged persons is more frequently a process than a sudden event, the process being one of very gradual, incapacitating decline of the mental faculties. An old man may begin to die ten or fifteen years before the absolute death of his body really occurs; and, like a tree, he may die beginning at the top and going down to the trunk. The decline in the moral faculties in old age may be shown in studying the lives of such men as Demosthenes, Cicero, Sylla, Charles V, Louis XIV, Frederick of Prussia, Napoleon, Voltaire, Dr. Samuel Johnson, Oliver Cromwell, Ruskin, Dean Swift, Milton, Lord Bacon, Webster, and Horace Greely. Old men decline in various faculties, some becoming peevish, others avaricious; some mean, filthy and tyrannical; others quarrelsome, sensual, unjust, revengeful, and ungrateful for past favors and kindness.

The best average barometer of mental force is the MEMORY, and decline or any deterioration in the power of the *memory* is the *advance guard* in old age, which sooner or later invalidates the forces of the brain. Most men show their mental powers in middle life, while their advanced years are the periods when they *apply* and *reap* the harvest of the work executed or planned in their palmy days. Thus Lord Bacon, Swift, Dickens, Ruskin, Thackery, Carlisle, Emerson, Wendell Phillips, Graefe, Pinel, Luther, Nelson, Harvey, Webster, Jenner, Jefferson, and Washington did their best work before old age got the better of them. Sterne said that "At sixty years of age the tenement gets fast out of repair"; and Emerson says, in his *Plea for Old Age*, "We cannot count our years until there is nothing else to count," and added, "We postpone our literary work until we find that our literary talent *was* a youthful effervescence which we have now lost." Dr. Oliver Wendell Holmes says: "New ideas build their nests in young brains, and the whisperings of *new truths* are not caught by those who begin to feel the need of an ear-trumpet."

Gen. Halleck in his work on "Military Science and Art," shows that mainly all the successful campaigns of history have been fought by comparatively young men, men in the prime of life, and that most of the early successes of Napoleon were gained over old and worn out generals."

In the late civil war of the States, the North began with old generals, and failure was the result, and the average of the later generals who finished up that contest was between thirty-five and thirty-nine years. We find the average age of the fifty-six Signers of the Declaration of

Independence was between forty and forty-five years.

Mr. Guernsey, of the New York bar, said: "From twenty-five to forty may be considered the *seed time* of life; that is, the time when knowledge is accumulated, and stored up for future use."

There are three causes of moral decline in advanced life:

First. Is the overtasking and overexercise through adult life of the physical and the intellectual faculties, to say nothing of early sexual abuses.

Second. Diseases of the brain, or of other organs, which react on the brain.

Third. Intellectual decline, or the gradual process by which all living beings decay and die.

The question of legal responsibility comes up in old age:

First. As to cases of crime by aged persons.

Second. Cases of wills, which are disputed on the ground of senile incapacity.

Third. When it is desired to fix the limit, as to term of office, etc.

Fourth. As to cases of priority of invention, etc.

Corruption in business and in political life, and breaches of trust are common among the old, as every day's papers inform us. Offenses which depend upon sexual passion are not infrequently among the aged, for it is well known that in the decline of life many return to the vices of their youth. Even clergymen, old men, have been charged with such irregularities.

*Cases of Wills* contested on the ground of senile incapacity are frequent enough, often giving rise to much trouble and enstrangement among members of the same family; and an evident presumption would often lead to an incapacity to dispose of by will wisely, the accumulated possessions of a life time.

A man in the decline of old age may be irresponsible more or less in one or more directions, while responsible in others. Few men break down all at once merely from decay of powers, but the faculties leave one by one, as one first becomes defective, or softened if of the brain, while the others remain for a while longer fairly healthy. As an army in retreat moves off, some holding their position while other regiments fall back. Thus the wear and tear of an aged person may be rapid, save where money, the touchstone of life, is concerned, for the old man cares rather for the money *in ipso*, than for the good that money can bring. Grudge or personal spite, unnatural enmity against a person, relative or not, often occurs in advanced age, amounting even to more than a disagreeable eccentricity, to almost a disease, and may influence judgement even against those who have been kind and affectionate toward the individual. It is difficult and generally fruitless to endeavor to remove this prejudice.

Then the aged are liable to be deceived by designing persons and have influences exerted over them which in their better day, they would have seen through or have not tolerated. The case of Horace Greeley may be cited as an instance of the irresponsible condition of an old man, he becoming inordinately fond of money as soon as disease invaded his brain, and yet he became insane the last week of his life and his will was disallowed.

When an old man, previously benevolent and wealthy, becomes in dread of the poor-house and begrudges the fuel for his family, the meat on his table, and the clothing for himself and his family, there is reason to suspect very serious cerebral disturbance, which might suffice to incapacitate him for making his will.

An instance may be cited of an aged clergyman, who all his life had been mean and penurious. In his golden decade, in his thirty-fifth year, he had been a minister of the gospel, a noted preacher. Between seventy and eighty he became worse and worse; becoming a geninue nuisance. He lost his memory and his manners; lost his wife; he then married again under the the most absurd circumstances; was then divorced from the wife, and again married. He then went into gross excesses; lost his physical health, which up to that time had been excellent, and finally lost all his money through the treachery of this last wife, who in the end deserted him in his poverty and in his imbecile condition. This man had during all these years made will after will. His friends now took him in charge and treated him as a confirmed imbecile.

Dr. Brigham, of Mass., says that in this country insanity and other forms of brain trouble are three times as prevalent as in

England, and Dr. Winslow, a celebrated expert in insanity, says: "In the incipient stages of cerebral softening, as well as in organic disintegration of the delicate nerve vesicles observed in what is termed progressive, general and cerebral paralysis, ending either in apoplexy or in progressive paresis or in childishness. In such cases the patient often exhibits a debility of the *mind*, of body and of *memory* more *especially long before* the disease of the brain is suspected in regard to the most trifling affairs of his life. He forgets his appointments, or goes to keep them before the appointed time. He is forgetful of the names of his particular friends with whom he has lived in the closest intimacy; he becomes irritable, mislays his book, loses his papers—he sits down to write on some matter of business and his attention being diverted for the moment, he forgets and leaves his letter unfinished."

The *memory* may be considered one of the most delicate tests of the presence of injury or of the progress of natural *mental* decay in the brain. The case is cited of an old man, who could never recollect the names of the inmates of his establishment, recalling *only* the initial letter of each one. He accordingly kept about him a list of their names so as to indicate them.

Old age, wear and tear will, like pressure from a bone on the delicate substance composing the brain, produce more or less complete death of the sentient being for the time. One of the early indications of softening of the brain is seen in the paralysis of the muscles of the face, *i. e.*, the drawing down of the eyelid, and the distortion at the angle of the mouth from paralysis of the corresponding muscles of the other side.

In many instances these irregularities and extravagances are but the premonitory symptoms of softening of the brain, that terrible malady, incurable and which gradually destroys, one by one, the powers of mind and body, and reduces the poor sufferer to a living death. Sensations as of cold, numbness, pain, and of increased warmth at times may all be felt in a perverted state; in some everything touched feels cold; others can bear only the lightest wraps in bed on the coldest nights of winter.

Prof. Simpson, of Edinburgh, knew persons with incipient signs of general *paresis* to complain of their fingers feeling like sausages, cold and fleshy; and it is well known that on the approach of a paroxysm some have had such a feeling about the tips of the fingers as to lead to the habit of biting their nails—and this habit is known to exist in many inmates of insane asylums. The manners in such people are very variable, being different only in that the feeling of numbness and inertia persist and are on the increase all the time with them; while in the adult healthy individual, if this condition comes on at all, it forms a brief attack following generally a recognized cause, and then leaves the party almost, or as well, as before the attack.

It is the opinion of many eminent physicians that there has been a large increase of brain diseases during the present century, and that this increase has occurred in an accelerated ratio in proportion as the strain in commercial and public life of the people has increased, making the struggle for position, for wealth, and even for existence so much more difficult than formerly, when man's ambition was to live simply and to follow the golden rule, thus requiring increasing struggle for the luxuries of life, which finally culminates in cerebral excitement under which the delicately organized brain is forced to yield. Eccentricity is but a name often covering painful afflictions, and any prolonged exaggerated conditions of eccentricity may be said to constitute disease (page 89, work on the Border land of Insanity, by Andrew Wynter, Esq., M. D., of London). Many mental eccentricities are but the *forernuners* of *serious mental* failure. The inability to grasp a stick, the continued numbness of the fingers, the loss of *memory* in small matters, are often indications of serious cerebral disturbance. Dr. Graves, of Dublin, a distinguished physician and writer, cites a case, who could never remember proper names, and Dr. Samuel Johnson, the great English scholar and writer, the author of the beautifully selected passages in Rasselas of the Happy Valley, would attempt in vain to repeat the Lord's prayer in English in his latter days, and yet he could repeat every word of it in Latin.

Dr. Samuel Rogers, the poet, in his later years, showed peculiarities of *memory*,

very like those of persons known to be suffering from disease of the brain; he even forgetting that he had been a poet. This is an uncommon form of loss of memory, for once a poet, a man thinks himself a poet forever. Throughout history from the ancient fathers to our own times, we find like failures for the period of old age. We need only cite the famous John Randolph and that great jurist Samuel Tilden, of New York.

In the bible we read of David and his follies of his old age; of Solomon and his foibles with the fair sex; of the valor to-day, and the cowardice to-morrow of Elijah, in his flight from Mount Carmel; all in the extreme old age; of Moses, the law-giver, who organized the Mosaic Code, finally disappearing and wandering in the mountains lost to memory and to history, so that with all his legal lore he had not the mother wit to keep his bearings, or to leave his final testamentary evidence for future generations.

It has been said in this trial that many cases might be cited in green old age, where great ability and wonderful acumen were maintained even to the day of death. Such cases when seen at all are like angels' visits, few and far between, and "they stand out like meteors in the midnight sky."

Now comes a review of the last great

> "Scene of all
> That attends this strange, eventful history,
> Is second childhood, and *mere* oblivion,—
> Sans teeth, sans eyes, sans taste, sans everything."

And we may add to this doleful picture, sans will, sans memory, and sans care for those who loved him.

See the picture of this poor old man, shrunken; not in his locomotor power alone, but in mind, and failing in his powers of memory, without which the noblest work of the Creator becomes useless, helpless, motionless and reasonless on the tide of life; is at the mercy of the slightest breeze by friend or foe—whichever most caters to his present whims; or like the feather tossed by the stormy waves, it was something once, but wilted and weighted down by the moisture of the sea, it is but a creature of chance. This old man was lame, blind, halt, toothless, and his "voice had fallen in tone from the mighty starboard watch ahoy!" to the childish, feeblest piping and whistling, like the tiny reed; or like the creaking door in his strength, left to rust and droop until no longer with any to care for it, in the end it tilts and falls, carrying danger in its fall. On top of and above all these three-score years and ten, he suffered from the Grippe, that prostrating, debilitating, life-destroying Grippe, which takes its name from the French word "tongs" or "seizings." The French are very *au fait* in their use and application of the proper words. This disease is known to the Italians as "influenza;" to the people of the far south as the "dengue" or break-bone fever, and in England as the "epidemic bronchitis." It is fearful in youth, prostrating to adults and fatal in old age.

In connection with all this disability, lasting many months, this old man attempts to publish his will. Often then he says to his brother and to his elder sister, "Don't you worry; I have *already* provided for you." He thought he had made this provision, no doubt, but on the contrary he *utterly* forgot to mention them. Poor old man! His good intentions took the place of good actions, which he thought performed, until at last he had neither will nor memory, but existed like a plant—simply on the sap that was left and on the light of other days. This honorable jury must forgive him, for he knew not what he did, being irresponsible, and living on the visions, the *ignis fatuus*, of past recollections—merely a creature of habit and repetition.

Thus his constant effort in business was a mere matter of habit and but the shadow remaining of his former good intentions towards those who were justly entitled to his benificence. He did not even recollect the amount of his income, nor did he provide for over one-third of it, and the little he did attempt to will, he divided to those he had foresworn. His *memory* was but a fume, a mist, like the froth on the beer glass—now present like a bubble, and then gone to rise no more.

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MISS SOFTLY (who has been attending a course of lectures)—Oh, professor, I saw such a funny old fossil in the museum today. I thought of you at once."—*Vogue.*

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"You ought to be very proud of your wife. She is a brilliant talker." "You're right there. Why, I could listen to her all night. I often do."—*Texas Siftings.*

# PROGRESS OF OTOLOGY.

LAURENCE TURNBULL, M. D, PH. D.,* PHILADELPHIA.

It is sad, but nevertheless true, that there are still some physicians who doubt the advance of our knowledge of the diseases of the ear, nor do they appreciate the great changes in the methods of treatment. And this is not to be wondered at, especially among those graduates and physicians who do not read the medical journals nor the new editions of standard medical works. However, we expect better things of men who are looked up to as authorities; leaders in the profession, who have every means of reading, *if they will*, the recent reports and literature on this special subject. Nevertheless such is the case, for great ignorance still exists to this day, as will be believed when we inform you that a young specialist came the other day to consult us about a patient he was treating. After having given directions and compared notes and mentioned the necessary advice, he continued, "I have great difficulty in having certain measures carried out. My orders as a rule are neglected because a relative of the patient, a well-known and leading physician, insists on urging his advice; which is to the effect, 'that the only successful cure of deafness is, in his opinion, syringing with soap and hot water,' and all other means of cure are of little use."

This occurrence is quoted as an example of most frequent experience. Most of my readers are well aware of the value we place upon the use of warm, antiseptic, alkaline solutions in the removal of impacted cerumen; and we always advise and urge their use rather than the employment of mechanical interference, such as the use of the steel or silver probe, spoon, or curette.

No aural instrument should be employed without an accompanying good light; and better than all, as reflected by the head mirror. It will be well just at this place to state, that impacted cerumen is a more frequent cause of deafness than is usually supposed, for in two hundred and fifty cases of diseases of the ear, there were thirty cases in which impacted cerumen, by pressure on the membrana-tympani, caused middle ear disease and impaired conditions with annoying symptoms; yet there are thousands of individuals who have their ears filled more or less with cerumen, which not pressing on the membrana-tympani permits fair hearing and causes no annoyance. Then again we have an army of patients that have diseases complicated or caused by such disorders as we enumerate: Nasal and turbinated bone congestion and obstruction; adenoid growths; naso-pharyngeal catarrh; hypertrophied and inflammed tonsils; scarlatina and measles; tropical effects; also in a reflex manner the menopause, irritation of the auditory meatus, cardiac disease, gout, uterine disorders, syphilis, rheumatism, pregnancy, "morbus Brightii," pneumonia; as also from alcohol, ozena, decayed teeth, quinine poisoning, gun concussion, exostosis of the meatus, catarrhal changes with closed or narrowed Eustachian tubes, perforation of the membrana-tympani, polypus of the tympanum, and disease in the labyrinth (internal ear).

This list shows the general relation of aural to other disorders, and will give a slight idea of the great importance of a correct diagnosis when attempting to treat this peculiar class of symptoms of so much importance to every diagnostician. It is well to have at hand the means of examining the ear with a good silver ear speculum, cotton holder, ear forceps, and above all a good head mirror of short focus, and bright, clear artificial light of oil, gas, or some form of steady electric light. There are many other important instruments for precision, without the use of which a correct diagnosis cannot be made; yet with a speculum and mirror, physicians could often save their patients long and expensive journeys, and spare their own reputation, by first using them carefully to make a diagnosis.

There is a peculiar disease of the external meatus to which we wish to refer as it will at times deceive the most expert. It is termed "desquamative otitis externa," and on inspection resembles the ordinary impacted cerumen so closely that at first sight one is easily misled.

The following is a brief report of an interesting case:

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J. A. T. was brought from the neighborhood of Philadelphia by a friend, who was also a physician, who had been treating him for acute otitis externa (desquamative). The disorder was the result of exposure during a cold night in February, when visiting in the country. The pain complained of was intense and the mental distress was very great, probably for fear of loss of hearing. Our friend had already attended him day and night, and had administered, during the night, two grains of morphine hypodermically, with various local measures which induced but temporary relief. On examination of the right ear, which was quite deaf, the meatus was found swollen and filled up with desquamating macerated epithelium. By aid of the forehead mirror and gaslight, the softened cuticle was removed with the forceps, and the lining membrane of the meatus was so congested in points that it bled at the slightest touch. The membrani-tympani was in the same condition. This was treated locally with hydrochlorate of cocaine ointment, ten per cent. in vaseline. The Eustachian tube was opened with the Politzer air douche, charged with vapor of chloroform. The patient was directed to use internally tincture of aconite, two drops and three drops of tincture of belladonna every hour; also, four grains of sulphate of cinchonidia, with the use of "ungt. hydrag. oxor. flav.," (gr. j to the drachm, and ¼ grain of morphia). This treatment was kept up and in three days all the painful symptoms had disappeared and his hearing was almost restored, without any perforation of the drum membrane or the involvement of the mastoid.

Numerous cases of this class are constantly brought to our notice in the Jefferson College Hospital as well as in private practice, especially during the months of February and March. If the cases are treated continuously they may be promptly relieved. Anodynes, heat and stimulants are all well in their way, but, like pontoon bridges, are only for the emergency which is bridged over with them, and are all to be discarded for the more decided constitutional treatment.

There are also some diseases of the auditory nerve which will be readily understood from the character of the noises in the ear (tinnitus aurium); or as reflex irritation and inflammation from various diseases which cause hemorrhagic inflammation of the cochlea or the labyrinth, particularly in children; primary acute purulent inflammation of the labyrinth resulting from meningitis, much like similar cases caused by syphilitic disease of the labyrinth; traumatism involving the internal ear, later causing atrophy of the labyrinth; changes in the auditory nerve from typhus, scarlet and other fevers, also from variola, diphtheria and mumps. It may also be comprehended how deafness can be an inheritance through a diseased father and mother. Yet the deafness which is charged to this cause is not as frequent as we would be led to suppose by the imperfect statistics of our institutions for the instruction of deaf mutes.

A large number of cases of loss of hearing are developed during the period of childhood when changes in the organs of hearing may occur—the result of colds, dentition, measles, whooping cough, scarlet fever and cerebro-spinal meningitis. The ears are apt to be overlooked in the great anxiety and fight for the life of the child. When the crisis is over then the poor, damaged ear is perhaps examined, only too late and to find the child profoundly deaf. No one can fully appreciate the parents' distress over a deaf child, especially a mute, and but few can understand the importance of hearing both for social intercourse and educational development, until some one near and dear has lost it.

It is an important matter that obstetricians should teach their nurses some knowledge of the anatomy and physiology of the ear, as the deafness of many of the so-called congenital deaf mutes is the result of post-natal changes. The meatus of the new-born babe is often filled with a cheesy matter, or it may be blood in the meatus or the tympanic cavity.

Another cause is from neglect to treat in time catarrhal deafness, the result of cold from teething or exposure. The nurse is often at fault for placing the infant in draughts of cold air, and for allowing water to enter the meatus and macerate the membrane, or lodging where it might cause acute inflammation. Pain and persistent earache is often not relieved until nature takes the reins and perforation of the drum membrane takes place with, it might be, subsequent extension to the internal ear and brain if not promptly cared for.

# COMMUNICATIONS.

## REPORT OF A CASE OF TWO SEPARATE AND DISTINCT UTERI, CENTRALLY SITUATED AND NOT CONNECTED.*

HANNAH T. CROASDALE, M. D.

The patient, aged sixty-three years, mother of three children, was admitted to the Woman's Hospital for treatment for an abdominal tumor.

Twenty years before, she noticed some enlargement of the abdomen, and in five years it reached, she thought, its present dimensions. No discomfort was felt (except from size) until recently, when she experienced pain and pressure symptoms, and the bladder and rectum became very irritable.

The menopause occurred at fifty, and at that time the woman was confined to bed for several weeks, but there was no especial reason given for this, or she forgot just why she was in bed for that length of time.

Her condition on admission was not very good, although no definite trouble could be found except a systolic heart-murmur. Lungs and kidneys were in good condition.

Pelvic examination externally showed a regular enlargement of the abdomen, and there was percussion-dullness from symphysis pubis to umbilicus and almost from crest to crest of the ilia, with a small area of tympany on the left side. The measurements, as noted, are as follows:

From umbilicus to ensiform cartilage, 8½ inches.

From umbilicus to pubic symphysis, 12 inches.

From umbilicus to right anterior superior spinous process of the ilium, 10½ inches.

From umbilicus to left anterior superior spinous process of the ilium, 10½ inches.

On making digital examination *per vaginum* the cervix uteri seemed small, apparently undergone senile atrophy, and it was pushed backward and high in the pelvis, the whole uterus being pushed backward. I thought the fundus looked forward, but the uterine sound did not pass readily, hence its use was not persisted in.

What seemed to be a fluctuating tumor was appreciated *per vaginum* to the right of this uterus and above the brim of the pelvis, and a small, tender mass was felt in the right parametrium. The patient complained of pain and tenderness when touched, especially on the right side.

*Diagnosis:* Fibro-cystic tumor of, probably, the uterus.

After the usual preparation the patient was etherized and the abdominal cavity opened. On opening the peritoneal cavity the omentum was found to be greatly thickened and congested and extensively attached to the tumor beneath it and to the pelvic walls. It was necessary to ligate and cut in many places, and upon pushing the omentum aside the tumor looked pale and felt and looked like a fluctuating mass. A trocar and canula being used, I was surprised that no fluid flowed through the canula.

The incision was now extended in the abdominal wall upward sufficiently to admit of the withdrawal of the mass entire.

A small nodular mass attached to the lower part of the tumor, having the shape and size of the uterus and being furnished with what seemed to be the uterine appendages, was drawn out of the lower end of the wound and was found to be attached by a small cord-like pedicle to the pelvic brim, a little below the crest of the left ilium.

Another body, to all appearances a uterus with its appendages, was found in the pelvic cavity and fixed by the usual attachments, but had been crowded into Douglas' pouch.

The slender pedicle, not larger than a pencil, which tethered the smaller mass to the pelvic wall was ligated and cut.

The tumor being now freed from its attachments, which were omental entirely, was lifted from its bed. This growth must have derived most, if not all of its nourishment from the establishment of the circulation through the omentum, for it had almost severed its attachment from

* Read before the Philadelphia County Medical Society, January 24, 1894.

other structures, and the omental vessels were enormously enlarged.

The abdominal cavity was cleansed and the opening closed with silkworm sutures, the dressings applied, and the patient was put to bed. Reaction was prompt and good. The temperature for the first four days ranged from 99° F. to 100.4° F. It then rose, and on the sixth day reached 102.6°F., and on the ninth day 105.4°F., when she died of sepsis.

The autopsy showed purulent infiltration at various points in the pelvic cavity. There was also found at autopsy a uterus and appendages in a healthy condition and in the proper position.

Sections from this little body, which hung from the large tumor, were sent to two pathologists. One reported the specimen as being that of the structure of a fibro-myoma. The other pronounced it uterine tissue, and some structure resembling the endometrium.

If this is a separate and distinct uterus, and I think it is, it is an unusual case, a unique case.

We know that bodies which are not properly situated are not well organized, and take on disease very readily. This second uterus had developed from its *cervix* a fibro-myoma. As it grew too large for the pelvic cavity and rose above the brim, the little organ was inverted and so hung suspended from it.

It measures from the internal os to the fundus one and one-quarter inches. The length and size of the cervical portion is exaggerated, evidently from the tension upon it, but as it was cut open in the fresh state it showed quite distinctly the arbor vitæ arrangement of the mucous membrane lining the canal, and the lips and cervical canal were quite natural in appearance. The os internum on the left side admits the passage of a small probe, which passes a little distance along the Fallopian tube. On the opposite side the opening would not admit of the passage of the probe. There are two small ovaries which, on being cut open, showed on macroscopic inspection ovarian tissue. No microscopic examination of this tissue has been made. In the cervical canal, just below the internal os, is a small calcareous deposit.

The didelphic uterus we have seen, and these cases are actually two uteri, separated as far as the cervix and including it, and not two bodies more or less divergent, as in the case of the uterus bicornis. Ollivier's specimen of a uterus didelphys, and divided vagina with a distinct cervix uteri looking each into its own vagina, was taken from a woman who had been pregnant five times. Each segment presented the appearance of a complete uterus, seeming to be two unicorn uteri equally developed and apposed without fusion.

It used to be thought that this malformation occurred only in nonviable embryos with deformities of other organs. It has been seen with ectropian of the bladder, with imperforate anus, and other malformations. But an entire organ, far removed from one in the usual location, I have not seen mentioned.

### CALCIFIED CORPORA LUTEA.

Another specimen is this little body which I at first thought was a lithopædion, but, seeing Bland Sutton's note on calcified corpora lutea, find it to correspond very closely with the description of two specimens which had been sent to him at about the same time. He considered them very rare pathological specimens. Dr. Voelcker secured one from an ovary of a woman who died of mammary cancer very widely disseminated, and he supposed the two little nodules in the ovary to be secondary deposits; but cutting into them found them to be concretions. One was encysted and had outwardly the appearance of a mulberry calculus of the bladder, the other was imbedded in the ovarian tissue and was of irregular shape.

When this specimen was fresh it was of a bright-yellow color, very characteristic of a recent corpus luteum. It cut as would wax, perhaps of firmer consistence.

Those specimens which Bland Sutton describes consisted of dense tissue impregnated with lime salts. Mr. W. A. Meredith speaks of examining a patient and distinctly feeling the hard body through the vagina, and it gave rise to the impression that the swelling might be the sac of an ectopic gestation containing fragments of bone.

Dr. Coe, of New York, recently described a similar body under the impression that it was a bony nodule.

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Greatest review in the world—Lost sight restored.

# A CASE OF ERYSIPELAS.*

P. GUNTERMANN, M. D., LOUISVILLE, KY.

Since erysipelas is strictly considered a surgical disease, I do not propose to discuss at length what does not seem to properly belong to the domain of the general practitioner, though he may have to deal with it quite as often as the surgeon. Yet, in order to excuse the report of an every-day occurrence, it becomes necessary to at least make a resume of the leading features then my case may seem to be *apropos*.

We know what erysipelas is. It is an infectious disease manifested by more or less dermatitis, inflammation of the mucous surfaces and also of the serous membranes. It is claimed, and I think justly so, that the first requisite is a wound, ever so small, through which the system becomes infected. The infecting agent is the "erysipelas coccus." That it is a disease communicable from one individual to another, from man to beast and *vice versa*. If it bears a close similarity, not to say, relationship, to other dermatites or erythema nodosum, eczema, etc. The positive differentiation is in the presence of the *erysipelas coccus* found in the blood, the tissues, etc., of the patient.

Erysipelas is conventionally classified E. simple, E. migrans, (fugax); E. nodosum, and E. gangrenosum.

The cause of erysipelas then is, first, a wound, and, second, the coccus erysipelas, a bacterium.

The symptoms, as a rule, are pronounced. It is ushered in with chilliness, a chill, or rigor more or less severe and prolonged. Soon fever sets in, and in most cases the temperature runs high and remains so until the disease abates. The skin is hot and dry, the tongue brown, parched and cracked. Often we have delirium and prostration, always if the disease is protracted.

The local signs make their appearance at the site of injury and infection; we have itching, redness, heat, pain and swelling. The intensity of all these depends on the individuality of the patient.

Erysipelas is more severe in old and debilitated people and those who have a peculiar disposition. There are persons who have this predisposition. The intensity also determines by which of the four varieties we will name the case on hand.

The diagnosis is comparatively easy and seldom, I dare say, are mistakes made in this direction.

The prognosis is nearly always favorable except in the pueperal state—very often fatal—and in the feeble and debilitated, or when complicated by other disorders particularly of the kidneys and contents of the cranium. Nephritic troubles are rather frequent complications.

The treatment is general and local. The systemic treatment consists in sustaining, stimulating foods and medicines, and antipyretics and tonics, occasionally anodynes, etc. Locally we use the different antiseptics in their different forms.

Prophylaxis is easy and ought never to be neglected but very strictly carried out. The patient ought to be especially cautioned to prevent relapses.

It may not be amiss to mention that the erysipelas bacterium has been successfully used in bringing on the disease artificially, for the cure of cancerous disease. It is a mooted question whether the cure is the result of nutritive changes or whether the cancer cells are directly destroyed by the new intruder.

The report of the following case shows in my estimation, all phases of erysipelas.

Mrs. P. is sixty-six years old, is thin and of wiry frame. She is the mother of nineteen (consecutive) children. Has always been well until the climacteric period at about forty-nine or fifty years. Since that time she has had 4 or 5 distinct and severe attacks of erysipelas. The last before this one was of exceptional gravity. The disease traveled all over her body and general septic trouble set in, attended and followed by a number of abscesses. Finally she recovered and was quite herself again until the present attack.

Patient in attending to her feet had wounded the big toe of the left foot. A few days later she became aware of the

*Read at a meeting of the Louisville Clinical Society January 2, 1894.

presence of the old enemy. On the 24th, day of November, 1893, a doctor was called who diagnosed erysipelas, prescribed and did not return. I saw patient for the first time on Nov. 28th, and thence almost daily, making my last visit Dec. 31st, 1893.

This was the patient's condition: High fever, temperature 104° to 105° F.; pulse 140; skin dry and harsh; tongue brown and cracked; great irritability and slight wandering; bowels and kidneys acted fairly well; the left foot and leg were enormously swollen, covered with large blisters, the contents of which were saneous, opaque and the surface underneath slightly granular tending to suppuration; a gangrenous patch at the inner malleolus, and the toe nails ready to drop. This part of the patient's anatomy had to bear the brunt of the infection.

From the knee up the disease migrated by daily making new invasions of the healthy skin. Up the thigh, over the back of the neck, down the left arm, up the neck over the hairy scalp and over the face, down the right arm, breast, abdomen and right thigh. So far the new invasion could be called *simple*. In the right leg and foot the swelling became very great, rivaling its companion. The constitutional changes became alarming. However the patient rallied, the local trouble subsided and she is convalescent.

The treatment consisted in liberal stimulation, light, nourishing food, large doses of quinine and tinct. ferric chloride. Locally I used a dry antiseptic powder covered by boric cotton. I always prefer dry applications, in this case, particularly, on account of the extent of the disease and the discharge from the numerous denuded surfaces.

## A COMPLICATED COLLES' FRACTURE.

E. J. KEMPF, M. D., JASPER, IND.

Mr. C. A. brought his seven-year-old girl to my office in January, 1894, accompanied by his wife. They said the little girl, on her way home from school, had fallen from a fence on her hands and had broken one of her arms. It was now two hours since the accident had happened; they had first called upon Dr. S—— but he was not at home.

I found the left arm of the little girl in a very curious shape. There was a green-stick fracture of the ulna near its upper third, and a Colles' fracture of the radius near the epiphyseal line. A good description of it would be a silver-fork deformity with the handle twisted.

The arm was pronated to the extreme, and could not be turned or supinated. The long axis of the arm was decidedly shortened. The ulna being partly broken (green-stick) at its upper third and bent outward, and the radius being broken at the epiphyseal line, it seemed to me as if one fracture wedged the other.

I explained the fractures to the parents of the child, and advised them to call in Dr. Brannock in consultation and to assist in the reduction of the fractures. This the parents would not consent to. I then explained to them the wedging of the two fractures, one by the other, and that I would have to give the child chloroform or ether, and that I thought it more than likely that one doctor would have to bend back the broken ulna, whilst the other doctor made counter-extension and extension in order to reduce the Colles' fracture of the radius. Furthermore, that a Colles' fracture was always a serious one; that it was sometimes followed by deformity and stiffness of the wrist, no matter how carefully it was reduced and treated; that this particular arm was fractured in a peculiar and unusual manner; that I had never seen one just like it, that I had never read of one just like it, and that it was possible that I was mistaken in my diagnosis of the fracture.

The mother was a child of the forest, or backwoods, and a great believer in *Natur'*. She could "not for the world see" why I made such "a great a-do" about the matter, and said, "Why, doctor! can't you fix it up?"

I answered, "What do you mean by that?"

"Why, get some shingles and tie it up. It'll come out all right. She's young, and she'll outgrow it; and if it is a little crooked, that won't hurt. I know my sister had her arm broken years ago, and never had no doctor at all, and it got all right. It's a little crooked, but she can use it and don't mind it. And my neighbor's boy had it's arm broken, and a doctor set it, and it was right crooked; but he don't mind it any more, and he can use it. Fix up the arm, doctor."

I then appealed to the father, but all he had to say was, "I've got nothing to say at all—at all."

So I picked up my hat and went after Dr. Brannock.

The doctor examined the arm and concurred with my diagnosis. He also insisted that the child be given chloroform, so that the fracture could be properly reduced without giving the child too much pain. But the parents were obstinate, and would not agree to the chloroform.

We now made two propositions to the parents. One was, that they go somewhere else to have the child treated; the other, that we reduce the fracture as well as we could, and that if any untoward deformity occurred, that they take the blame.

They eagerly accepted the latter proposition.

Accordingly I clasped the fingers of the child's hand into my fingers and made forcible extension of the wrist, at the same time I pressed the fragment of the broken radius down into the position; whilst Dr. Brannock took hold of the forearm, with his fingers above and below the fractured point of the ulna, and with his thumbs forced the ulna into a straight line. We used considerable force, but we accomplished our purpose quickly. Whether the lower fragment of the Colles' fracture was completely reduced we could not tell, because the limb was now very much swollen and very painful, and the parents would not allow further manipulation.

After reduction of the fracture, we placed the hand in flexion on a Levis' metallic splint, and bandaged up the arm.

In four days the mother brought the child to my office and I found the arm in good condition. I instructed her to come back in a few days again, or sooner if there was much pain or swelling.

The patient never came back, and what the outcome of the matter is I do not know.

*Remarks:* I have given a history of this case just as it occurred, and now I call attention to a few lessons to be derived therefrom.

*First.* There seems to be an idea among non-medical people that to fix up a fracture consists in putting the limb into some apparatus and then bandaging it up. Whilst this is a very important factor in the proper and successful treatment of fractures, the first and most essential point is the *proper reduction of the broken bone.* If the broken bone is not well reduced, deformity is bound to occur.

*Second.* There are some people who believe that if a doctor has once handled a broken limb and bandaged it up, the after-treatment is of no consequence. Case after case could I relate as having occurred in practice, that I never saw after the first handling of the broken limb.

*Third.* There are some people who are insanely afraid of an anæsthetic, just as there are some who have a holy terror against vaccination, against calomel, against quinine, against baths, etc. And if you trace this mania to the root, you will always find it due to the foolish talk of some doctor who had more tongue than brains.

*Fourth.* If a doctor meets with a case of fracture where the patient himself, or those who are in authority over him, refuse to comply implicitly with the suggestions of the doctor, let him at once either refuse to treat the case, or insist on having a consultation with some other responsible surgeon or physician. If then a suit for malpractice does come up, the attending physician will have a witness worth a ton or two of medical expertism.

*Fifth.* Was it my duty to hunt up the case after the patient failed to come to my office or send me word is a question that I could only answer, "Yes, for my own protection" had there not been a consultant at the first visit, who was acquainted with all the circumstances.

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"Well, what did your wife give you for Christmas?"

"Why, it was a–er let me see, a very fine–ah–dear me! I can't remember just what it is but I know it is very becoming to her.—*Washington Star.*

# A NEW METHOD OF EXAMINING THE KIDNEY, ESPECIALLY FOR STONE.*

CHARLES P. NOBLE, M. D.†

I desire to report a short history of the following case, together with an exploratory operation which I performed to enable me to examine her kidney, including the pelvis of the kidney and perhaps one inch of the ureter.

Mrs. T. S., aged thirty-seven years, mother of three children, enjoyed good health until six years ago. Since that time she has been more or less an invalid, unable to attend to her duties. The prominent points in the history are that she has had three well-marked attacks of hæmaturia accompanied by violent renal colic (so-called) and that, at least twice, she has passed good-sized stones, the last one coming from the left kidney. In addition to this history of violent seizures of renal colic, she has suffered frequently with milder attacks of paroxysmal pain referred to the region of the right groin, the pain being, perhaps, most acute just above the right trochanter major. Recently these attacks have been of daily occurrence, and have been brought on when she was on her feet. She is, usually, but not always, comfortable when in bed, but shortly after any attempts at walking the pain comes on. The sexual organs are normal, with the exception of a trifling tear in the perineum. The urine has been examined many times and has a very uniform composition. Its specific gravity has varied between 1020, 1013 and 1018; it is acid, and contains pus, bladder epithelium, and ureteral epithelium, but none from the pelvis of the kidney. The urine from each kidney has been examined separately—the urine being obtained by means of the ureteral catheter. Examined in this way it has been found that the urine from each kidney is much the same, the pathological elements it contains being somewhat more marked on the right side. This difference, however, was distinctly marked with reference to the two sides. The urine from the left kidney has always flowed through the ureteral catheter freely and regularly; that from the right kidney has not done so. Upon two occasions the ureteral catheter remained in position upward of twenty minutes, and not more than one or two drops of urine flowed out. Upon another occasion, after waiting thirty minutes with the same result, suddenly one hundred and twenty minims poured out.

Taking all the facts of the case into consideration the conclusion seemed fair that there was a stone in the right ureter, and that probably this was in the pelvis of the right kidney. Several attempts were made, both by Dr. Howard A. Kelly and myself, to pass a ureteral sound along the ureter toward the kidney. It was not possible to make the sound reach above the brim of the pelvis. It was therefore proposed that an incision be made in the loin for the purpose of examining the kidney and the upper portion of the ureter from above.

My experience in performing nephrorrhaphy for movable kidney after the technique of Dr. Edebohls, has taught me the facility with which *a movable kidney* can be drawn out through an incision in the loin. So far as I know, no one has ever treated a non-movable kidney in this way. It occurred to me it might be feasible, and that, at all events an attempt judiciously made could hardly be a source of danger.

Accordingly on December 12th, I made the usual incision in the loin down to and through the peri-renal fat, exposing the lower end of the kidney. With the index finger the kidney was then separated from its connective tissue attachments and gradually drawn down into and out through the wound, so that it was entirely outside. It is now a very simple matter to explore the kidney by thumb and finger pressure, and to make certain that it was in a normal condition. It was equally easy to examine the pelvis of the kidney, and to determine that this contained no stone. Perhaps one inch of the ureter also was within reach.

As nothing abnormal could be felt, the kidney was replaced within the abdomen and the incision was sutured in the usual

* Read before Philadelphia County Medical Society, January 24, 1894.

† Surgeon-in-charge of the Kensington Hospital for Women, Philadelphia.

way—buried silkworm-gut sutures being placed in the muscular layer, and superficial silkworm gut sutures in the skin. No unfavorable reaction followed this operation, and so far as the operation itself was concerned the patient made an uninterrupted recovery. Unfortunately the operation had produced no effect whatever on the symptoms, which are the same now as before it was done.

I report the case simply to bring before you this method of examining the kidney. From my experience in this case and in cases of movable kidney, I believe it will be a simple and safe matter in the hands of a skilful surgeon who has had some experience in kidney work, to remove through an incision in the loin all non-suppurating kidneys having approximately the normal size, for the purpose of a careful examination. The procedure is certainly not one of much gravity, and when done under the conditions laid down should have no mortality. Tentatively I would recommend the adoption of this method of exploring the kidney whenever the symptoms point to the presence of stone in the kidney or its pelvis, and when these symptoms are of sufficient gravity to invalid the patient. I feel confident that as compared with the ordinary method of exploring the kidney through the depths of the incision in the loin, the kidney itself being largely or wholly above the level of the ribs, and imperfectly palpated because of its movability, or examined by means of a puncture with an exploring needle, that there can be no question of the superiority of the method proposed and herewith reported.

Upon theoretical grounds this procedure would not be applicable in cases of abscess of the kidney. Under these conditions, supposedly the kidney would be fixed and not easily separated from its connective tissue bed. Moreover, it would be enlarged, and in addition to this there would be the risk of rupturing the pus sac, perhaps inadvertently into the peritoneal cavity.

# TRANSLATIONS.*

## THE INFLUENCE OF INTERSTITIAL INJECTIONS OF SALICYLATE OF MERCURY UPON THE EXCHANGE AND ASSIMILATION OF NITROGENOUS MATERIALS FROM A QUANTITATIVE AND QUALITATIVE STUDY IN SYPHILITICS.

P. Froloff, of Saint Petersburg, (*Le Progrés Medical*, August 12, 1893), remarks that the views of writers upon the influence of mercury upon the metamorphosis of nitrogenous materials in syphilitics are very various. According to Güntz and Liégeois the interchange is increased, while according to Boëck and Hallopeau, mercury has not any influence upon the exchange within the organism and the production of urea. Lépine and Rémond believe, on the contrary, that mercurial frictions dimish the quantity of nitrogenous compounds in the urine. The same view was held by Stepanoff, Vajda and Rambach, whose works were published in 1875–76.

All of the observations, the number of which is insufficient, do not agree with the conditions laid down by Voit, since all the authors quoted, with the exception of Boëck, have studied the exchange without determining the quantity of nitrogen introduced with the food and eliminated with the alvine dejections.

Noticing this diversity of opinion upon a question of so great importance, and the almost universal defect in the studies upon the subject, Froloff has made a study of the assimilation and exchange of nitrogenous materials in syphilitics under the influence of the mercurial treatment. He selected from the other modes of treatment the introduction of mercury into the organism by interstitial injections of the salicylate of mercury in suspension in liquid vaseline. In the course of his work,

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D., and F. H. Pritchard, M. D.

when the greatest part of his experiments were already completed, appeared the thesis of Dr. Jakovleff, "Upon the Metamorphosis of Nitrogenous Substances in Syphilitics during the Primary Eruption." In this, he observed that results almost identical with his, were obtained in patients submitted to the mercurial treatment by entirely diverse methods. A portion of his conclusions were absolutely analogous to the conclusions of the author cited. Jakovleff chose his patients among recent syphilitics during the recent incubation, and at the commencement of the eruption. In three cases the author had observed the patients without treatment; in three cases the patients were submitted to frictions at the onset of the roseola, and finally in one case, daily subcutaneous injections of the bichloride of mercury were employed. Basing his views upon these severe cases observed closely and for some time, the author has arrived at the following conclusions: 1. The exchange of nitrogen in the period of the first eruption considerably increased, notwithstanding that the temperature remains normal. From a qualitative point of view, the exchange falls. 2. The assimilation of nitrogen from the food diminishes in the same period. 3. Under the influence of mercurial frictions the assimilation of nitrogen is notably improved, the exchange diminished and oxidation increased.

Froloff has studied his cases, not only during the period of the primary eruption, but also during the secondaries. The last experiments were undertaken in the hope that in the secondaries the effects of the mercurial medication would be cleaner, and could be more easily differentiated from the effects of the disease itself. In all he had observed, eleven cases, six of which were syphilitic, with the secondary manifestations and the condylomatous period, and five with the early forms of the primary eruptions. Two patients in the first group were submitted to injections of pure liquid vaseline. One of the patients of the second group was also submitted to injections of pure liquid vaseline during the whole duration of the observation. Each experiment had a duration of from twelve to fifteen days, and was composed of four to five periods of three days, without counting the time necessary to cause a state of equilibrium. The patients were held a fixed regimen. Oxidation was made according to the method of Kjeldal. The quantity of nitrogen in the feces and urine was determined daily by the volumetric method in the apparatus of Borodine. Moreover, each day, in the same manner the quantity of nitrogen in the urea and extractives was determined by the method of Lépine and the uric acid according to the method of Haykraft. The presence of mercury in the urine was determined by the method of Votz. The following conclusions were reached: 1. The injection of salicylate of mercury in suspension produced in syphilitics with the relapsing forms, an increase in the exchange; this increase is sometimes very marked; while during the injections of pure vaseline, which of itself seem to have no action, the exchange fell. 2. From the qualitative point of view the exchange was most complete. 3. The assimilation of nitrogen diminished a little in the same patients. 4. It was noticed in the patients with the recent forms, in whom the exchange was greatly increased, that under the influence of the injections, the exchange of nitrogen fell with diminution in the urine of the products of incomplete oxidation, and the assimilation improved. —W.

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## COCAINE IN OTITIS MEDIA (Acute).

Wolfstein recommends cocaine in middle ear disease. He claims it to be an abortive, a preventive against suppuration, and an anodyne. The modus operandi is as follows: Instil into external meatus five to six drops of a five per cent. solution of hydrochlorate of cocaine. Pain disappears in from ten to fifteen minutes. Repeat if necessary. Two to three days treatment consisting of four to five instillations daily are sufficient to cure. In very severe cases repeat this treatment daily, and if necessary use an eight or ten per cent. solution.—*Allg. Med. Central Ztg.* —M.

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## PROSTATITIS.

Ullman recommends following:

℞ Ichthyol.....gr. viiss (0.5).
Extr. Belladonna.....gr. ii (0.15).
Butyr. cacao.....3iv (15.0).
Met. ft. suppos. No. x.

Sig.—Use once or twice daily after evacuation of bowel.

—*Memorabilien.* —M.

## SUPPURATION OF OVARIAN CYST AFTER TYPHOID FEVER.

Prof. Werth (Kiel) removed a dermoid cyst which was suppurating. Typhoid bacilli were found in pure culture. The patient had typhoid fever from October to November, 1891, and applied for treatmenton June 2, 1892, to Dr. Werth, on account of abdominal swelling and pain.

On opening the abdomen the cyst wall tore, showing very thin pus, sebaceous matter and short, thin hair. The cystic fluid showed under the microscope few leucocytes and considerable detritus. No bacteriæ were found. The contents of the cyst were introduced into gelatine, showing, after a few days, pure cultures of the bacillus of typhoid fever.—*Deutsche Med. Wochenschrift.* —M.

## TREATMENT OF AMENORRHŒA.

Dr. D. Labbé (Paris) reports three cases treated with the negative pole (cathode) of a constant current. The positive electrode is applied on the lower part of the abdomen in the linea alba. Applications did not exceed 5 minutes at a time. The intensity of the current was never more than 50 milliamperes. Instruments used should be made aseptic and in all cases the operator should convince himself that the uterus is empty.—*Jour. de Médicine de Paris.* —M.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.

### CORNUTINE DURING THE PUERPERIUM.

Dr. Krohle (*Il Raccoglitore Medico*, No. 16, 1893) thinks that cornutine, which Kobert holds to be the true active principle of ergot, if administered during the puerperium exerts a favorable influence upon the uterine involution. He uses the following formula:

℞ Cornutine.....3 cgms. (gr. ½).
Potter's clay.....3 gms. (grs. xlv).
Water.
Glycerine, ana..... q. s.
Sufficient for twenty pills. Six pills per diem.

It is indicated after extraction of the placenta and the membranous residua after abortions. In cases of sub-involution, or where the lochia remain a long time sanguinolent in puerperal endometritis, and, finally, after normal labor to hasten restoration to the normal condition. It is, on the contrary, contra-indicated in hemorrhages during pregnancy and, in weak contractions during the period of dilatation and expulsion.

### PHENOCOLL IN MALARIC ENLARGEMENT OF THE SPLEEN.

Prof. Cervello (*Il Raccoglitore Medico* No. 1, 1893) of the University of Palermo, in a monagraph on phenocoll, asserts that he has observed a notable retraction in size, of the malaric spleen in patients under his care. It is peculiar that other observers have not noticed this. Dr. E. Michell, also claims the same results. He employs intra-splenic injections of a saturated solution, and though it was used but a short time, and in only two subjects, a remarkable reduction was observed in a short time. With this reduction there was also an improvement of the local and general symptoms. The number of red-blood corpuscles was increased over one-third.

### FOREIGN BODIES IN THE ŒSOPHAGUS.

Dr. Ott (*Der Aerztliche Praktjker*, No. 48, 1893,) was consulted by a patient, who, eight years previously, had swallowed a piece of glass. A sound was introduced into the œsophagus, and came in contact with a hard body, at a level with the head of the sternum, which was apparently fixed in the anterior wall of the œsophagus. An attempt at extraction with a long and curved forceps did not succeed. He had no other instrument so that he was obliged to improvise the following: He took a new and very compact sponge and cut a piece out, the shape of a nine

pin, one inch and a half in length and three-quarters in breadth at the base. It was then perforated with a trocar, an urethral bougie pushed through this opening, and carefully tied to the sponge. Besides that he fastened a long thread to the sponge in order to be able to withdraw it in case that the bougie should break. The sponge-tipped bougie was then pushed down below the fragment, and in a few minutes the sponge had swollen so that it filled the entire œsophagus. It was then slowly withdrawn and with it the splinter of glass. Hemorrhage was quite severe, but it yielded to swallows of ice water.

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PHENACETINE IN INTERMITTENT FEVER.

Dr. Bernheim (*Il. Raccoglitore Medico*, No. 12, 1893,) claims that phenacetine is capable, like the sulphate of quinine, of suppressing the attacks of intermittent fever, if only it be administered in the proper doses and at the right time. Its action is manifest after an hour, reaching its maximum in two hours and ceasing in five to six hours. Hence it follows that it is best given from two to three hours before the onset of the attack. A dose of one gram (fifteen grains) is preferably given at first, and in obstinate cases, one-half to one grams (seven-and-a-half to fifteen grains) two hours before. No inconvenient or disagreeable results were observed. The lowest temperature is not obtained until five to seven hours after the administration. It differs from quinine in producing antipyresis of shorter duration. Its influence may extend over twenty-four hours. Therefore, from its transient action, the attack in some cases may only be retracted. He does not regard the sulphate of quinine as a specific in the true sense of the word in malaria, for it does not act as an antiseptic, but as an antipyretic. The other antithermics, given in convenient doses, and at the proper times, also act in the same manner as quinine.

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NERVOUS ASTHMA.

Dr. B. Schuermayer (*Medicinische Neuigkeiten*, No. 1, 1893) recommends in nervous asthma the use of Lebert's pills, containing arsenic, quinine and atropine for they will act when all other preparations fail. They have often the disadvantage that the atropine is not well tolerated and causes terrific dryness of the throat. The iodide of soda is also praised but it alone soon loses its action. If introduced into Lebert's formula it acts, with all the force of atropine and without its disadvantages. The two formulas are as follows:

℞ Atropine sulphate.....3 cgms (1/24gr)
Arsenious acid .....6 cgms (1 gr)
Quinine muriate..... .....4 gms (3j)
Extr. gentian .....4 gms (3i)
Sufficient for sixty pills. One to four pills per diem.

℞ Iodide of soda.... .....¼ gms (grs. xlv-3j)
Arsenious acid.....6 cgms (1 gr)
Muriate of quinine.....4 gms (3j)
Extract gentian.....3 gms (grs. xlv)
Althæa root.....5 dgms (grs. vijss)
Sufficient for sixty pills. One to six per diem. Three are a moderate dose though it may be increased.

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DYSPEPTIC VOMITING IN CHILDREN.

Dr. Tordeus (*Il Raccoglitore Medico*, No. 1, 1893) speaks highly of the following mixture in the dyspeptic vomiting of children:

℞ Pure creasote.....2 4 gtts
Distilled water..... 35 gms (3j. 3j)
Syrup of orange peel.....15 gms (3iv)
A teaspoonful every two hours.

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CONVALLARIA MAJALIS IN HEART AFFECTIONS.

Dr. Constantin (*Il Raccoglitore Medico*, No. 1, 1893) has employed this drug for a long series of years, in diseases of the heart and claims to have obtained excellent results.

It is a tonic to the myocardium and its influence is felt, little by little, so that it reaches its highest point in ten to twelve days, after beginning its administration. Not all its preparations are equally efficacious. Convallarine, convallamarine and the alcoholic extract are absolutely to be rejected as they yield but uncertain results. The watery extract, on the contrary, seems to him to be capable of giving good results. It is constant in its effects, simple in its preparation, two chief reasons for its suggestions in practice. He usually prescribes the following:

Thymol.....1 gm (grs. xv)
Infuse for five minutes in water 200 gms (3jvss)

Then add—

Watery extract of convallaria 10 gms (3ijss)
Syrup of orange peel.....90 gms (3iij)
To be taken in doses of fifty grams (an ounce and a half- a day) for six consecutive days.

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SWEATY FEET.

Prof. Kaposi (*Medicinische Neuigkeiten*, No. 32, 1893) recommends, in the treatment of sweaty feet, the following:

℞ Naphthol.....5 gms (ʒj ¼)
Glycerine.....10 gms (ʒijss)
Alcohol.....100 gms (ʒiijss)

Wash the feet morning and evening with this mixture and then dust with the following powder:

Powdered naphthol.....2 gms (grs. xxx)
Powdered starch.....180 gms (ʒvj)

Every morning one may dust into the shoes the following powder:

℞ Powdered talc.....40 gms (ʒjss)
Subnitrate of bismuth.....45 gms (ʒjss)
Permanganate of potash.....3 gms (grs. xlv)
Salicylate of soda.....2 gms (grs. xxx)

PSORIASIS.

In the *Medicinische Neuigkeiten*, No. 32, 1893, the following is recommended in psoriasis:

Chrysophanic Acid.....10 gms. (ʒiijss)
Chloroform.....90 gms. (ʒiij)

To be mixed with a solution of ten grams (two-and-a half drachms) of gutta percha, in ninety grams (three ounces) of chloroform.

WHOOPING COUGH.

Dr. J. Roca (*Arcivos de Gineclogia e. Pediatria*, No. 36, 1893) advises the following preparation, in the treatment of whooping cough:

Distilled Eucalyptus Water.....120 gms. (ʒiv.)
Cherry Laurel Water.....3 " (gtts. xiv.)
Hydrate of Chloral.....2 " (grs. xxx.)
Syrup of Belladonna.....25 " (ʒv.)
Syrup of Codeine.....15 " (ʒiv.)

A teaspoonful every three hours.
The patient should remain in the house, and the air disinfected with a 2: 100 solution of carbolic acid.

CHRONIC DYSPEPSIA IN INFANTS.

Dr J. Roca (*Archivos de Ginecologia e Pedriatria*, No. 36, 1893) states that in such cases the object to be gained is an increase in the acidity of the stomach, by means of either hydrochloric or lactic acid. He employs the following formula:

Hydrochloric or Lactic Acid..... 2 gms. (gtts. xxx.)
Water..... 95 " (ʒiij.)
Syrup..... 65 " (ʒijss.)

A teaspoonful twenty minutes after nursing.

Hydrochloric Acid,
Lactic acid..... āā 1 gm. (gtts. xv.)
Water..... 98 " (ʒiij.)
Syrup..... 75 " (ʒijss.)

Dose, the same as the proceeding formula.

If there are positive signs of dilatation of the stomach, washing out the stomach with boiled water is indicated. Even without dilatation it will give good results, especially before administering the acid.

SENILE INFILTRATIONS OF THE CORNEA.

Dr. Bimbacker (*Hospitals Tidende*, No. 20, 1893) communicates two cases of infiltration of the cornea, in elderly patients, which condition is sometimes met with in old subjects. It takes place into Bowman's membrane and, therefore, is covered with epithelium. After cocainization the supervening epithelial layer is removed by means of a camel's hair brush. A slight quantity of a five-per-cent solution of hydrochloric acid is then applied to the infiltration which, being the phosphate of lime disappears. Any remaining acid is neutralized with a solution of soda. In these cases the reaction is unimportant, and the slight obscuration of vision, which may follow vanishes in the course of a few months.

DYSENTERY AND DIARRHŒA.

Dr. Gelpke (*Archivos de Ginecologia Pediatria*, No. 55, 1893) recommends, in dysentery and diarrhœa of whatever origin, the following formula:

Pomegranate Bark,
Simaruba Bark,..... āā, 5gms. (ʒj¼).
Macerate in for twenty hours in,
White brandy,..... 375gms. (ʒxij).

Six to eight teaspoonful in twenty four hours. In children a teaspoonful.

This formula he has found to be an absolutely certain remedy, in the treatment of dysentery and diarrhœa of any origin. Dysentery will yield in four to eight days, even in the most rebellious cases. It is of especial service in infantile and summer diarrhœas.

A DELICATE TEST FOR ALBUMEN IN THE URINE.

Dr. F. Spiegler (*Giornale Speciale di Farmacia*, No. 12, 1893) recommends the following reagent, in testing for albumen, in the urine:

℞ Distilled Water,.....200gms. (ʒvjss).
Sublimate,.....8gms. (ij).
Tartaric Acid,.....4gms. (ʒj).
Cane Sugar.....20gms. (ʒv).

Some of the reagent is poured into a test tube and the urine is added, little by little, after previously being filtered and acidulated, taking care that the two fluids do not mix. If it contain albumen, there appears at the point of contact, a white precipitate at the zone of separation. This reagent will detect one part of albumen in one hundred and fifty parts of urine.

In all the affairs of life, social as well as political, courtesies of a small and trivial character are the ones which strike deepest to the grateful and appreciative heart. —*Henry Clay.*

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SATURDAY, MARC 3, 1894.


## EDITORIAL.

### TUBERCULIN AND ITS VALUE IN DIAGNOSING TUBERCULOSIS IN CATTLE.

Although the use of tuberculin is gaining favor among certain physicians in the treatment of tuberculosis, the best use to which this bacterial product is being put appears to be in the diagnosis of tuberculosis in cattle. The ravages of tuberculosis in the human species, its unquestioned contagiousness and the identity of human and bovine tuberculosis, all conspire to a more careful inquiry into the existence of this disease in cattle. Although rapid advances are being made in the treatment of tuberculosis, the only wise and ultimately satisfactory course to be taken in the line of eliminating the disease, is to cut off, as far as possible, the channels through which infection come.

Much stress has already been laid on the isolations and sanitary methods to be followed in caring for tuberculous patients in order that they may not infect others. The growing sentiment in this direction gives hope that the time is near at hand when there will be little danger of the spread of the disease from patients to family or attendants.

The next most serious channel of infection is believed by many sanitarians to be through the use of milk from tuberculous cows, and the meat from tuberculous cattle. As Americans cook their meat more thoroughly than most Europeans, the danger from this source does not appear to be so great for us as some of the European investigators have thought. There is, however, much difference of opinion on this subject.

In the danger attending the use of milk from tuberculous cows there is less opposition. It was demonstrated some years ago that *tubercle bacilli* could pass into the milk, and therewith the scientific proof of the possibility of infection through the use of milk was furnished. Numerous experiments have been made with the milk from tuberculous cows to determine under what circumstances the milk is to be considered dangerous. From these experiments the conclusion has been reached by many in-

vestigators that the milk of cows affected with udder tuberculosis must be considered infectious, since it contains almost invariably—some say always—tubercle bacilli. It has furthermore been clearly shown by a number of illustrations that this milk of tuberculous cows, not suffering from udder indurations, was infected with tubercle bacilli. Thus Bang* found the milk infections in nine out of sixty-three cows without udder disease. Although other investigations could be cited the facts stated are sufficient to call attention to the importance of knowing that the cows from which the milk is obtained are not tubercular.

The discovery of tubercle bacilli in milk, while a possible task, is a very difficult one. The diagnosing of tuberculosis in cows by means of inoculating guinea-pigs, or rabbits with the milk from the suspected animals, has proven to be a very long and often unsatisfactory proceedure. It is also, a well-recognized fact among veterinarians that cows may be sufficiently diseased to render their milk dangerous without exhibiting any physical signs or symptoms by which the disease could be detected. So insidious is this disease in cattle that it is usually well established before the health of the animal is appreciably affected. This renders a test more delicate than heretofore known, imperative, if the herds which furnish our milk supply are to be freed from tuberculous cows. It is in these cases that *tuberculin* is rendering so much service.

The value of tuberculin in diagnosing this disease, can be better understood by referring to actual tests.† M'Fadyean found it satisfactory in thirty-one out of fifty tuberculous (determined by post-mortem examinations) cattle, and in a later‡ test of twenth-three animals, all in an excellent condition, but one thirteen years-old cow, all were found to be tuberculous. Eber § reports positive results in 84.5 per cent. of a large number tested. M'Fadyean adds: "That taking full account of its imperfections, tuberculin is the most valuable means of diagnosis in tuberculosis that we possess. * * * It is probable that by using the tuberculin test twice, with an interval of some days between the injections, the proportion of errors in diagnosis would be very small." These and similar results obtained by other investigators are gratifying, as in the great majority of these cases the disease could not have been diagnosed ante-mortem without its aid. The thorough inspections of farm herds with this test would soon enable the owners to weed out the diseased animals and eliminate much of the danger from this disease to the coming generations, thus conferring a blessing upon the future herds of cattle as well as upon the consumers of the milk.

In recognizing the great importance of making an early diagnosis, the questions are often asked by interested parties, Where can I get the tuberculin? How can the test be made?

It may not be known generally, but it is a fortunate fact, that *Koch tuberculin* can be purchased in New York. It is somewhat expensive, however, although the preparations of it would be comparatively inexpensive if a large quantity could be used.

*Tuberculin* is made from cultures of the tubercle bacillus, and consists of a substance elaborated by the growth of these bacteria. The danger attending the handling of this germ and the consequent preparation of tuberculin by inexperienced bacteriologists or chemists, precludes the practicability of the home preparation of tuberculin, excepting the city or state authorities employ a man for this purpose

*Tedskrift of Veterinare, 1891. Heft, 5.

† *Journal of Comparative Pathology and Therapeutics*, Vol. VI. 1893, p. 120.

‡ Ibid. Vol. VI, (1893) p. 314.

§ Deutsch Zeitchrift f Thiermedicin Bd. XVIII (1892) p. 321.

and provide him with the necessary apparatus. It is hoped, that the Boards of Health will soon provide a laboratory or laboratories where tuberculin can be secured at a slight expense. It is not improbable that the growing demand for this article will soon become sufficiently great to warrant the undertaking of its preparation as a private enterprise. As the strength of each separately prepared lot of tuberculin should be *thoroughly tested* before it is used in diagnosing the disease in questionable animals, it is hoped that the health authorities will supervise its production, that every dram of the substance that goes upon the market or that is used by state inspectors may be efficient. The answer to the first query is, that, at present, the tuberculin can be purchased the same as other medicine.

The method of applying the test is quite simple. The desired quantity (determined by the strength of the tuberculin) is injected beneath the skin of the animal. If the animal has tuberculosis, no matter how slightly affected, the temperature rises from one to five degrees within six to twelve hours. The subject, over which there is much discussion at present, is the cause of error in the temperature reaction. M'Fadyean had nineteen tuberculous animals out of fifty tested, fail to give the reaction, and five others that gave the temperature reaction were found upon post-mortem examination to be tuberculous. He took the temperature of 103° F. as indicating a reactoin, however, which seems to be somewhat arbitrary and it may explain some of the discrepancies in his experiment. Physiologists have found that the temperature of animals varies in the same individual from 1 to 3° F. during the twenty-four hours. In making the test therefore, the temperature of the animals should be taken as often as every two hours for at least twelve hours before the injection and as often after the injection of the tuberculin (after four to six hours) for twelve to eighteen hours. Should the maximum temperature after the injection be higher than the maximum temperature before it, the excess could be considered as a reaction. In M'Fadyean's (l. c.) list of twenty-three animals, all tubercular, the maximum reaction was 4.4° F. over the temperature of the animal before the treatment. The elevation was detected in some animals in four hours after the injection and in others not until twelve hours had elapsed.

In view of the great danger to mankind of tubercular milk, the benefit that will assuredly come to cattle owners by eliminating this disease and all its predispositions from their herds, and the most comforting of all facts that the disease may be detected in its incipient stage by the aid of tuberculin, the hearty coöperation of all men concerned in the elimination of this disease, is most earnestly commended. In this way the good that will come to the human race through Koch's discovery may eventually become greater than it was hoped when tuberculin promised to be a specific. The most important work for sanitarians to accomplish is to *cut off the known channels of infection*, and tuberculosis in cattle is a menace to the health of the people.

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"Made an awful mistake at the Gotrox's reception. Stepped up to one of the guests, and told him to order me a horse and carriage." "Did he do it?" "No. He called me an ass."—*Indianapolis Journal.*

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**Rheumatic Fever.**

℞ Tinct. Aconite Root..... ½ drm
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1½ ozs
Ess. Pepsine..... 1½ ozs
M. Sig.: Tablespoonful every two hours.

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**Myalgia.**

℞ Salophen..... 1 drm
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1½ ozs
Spts. Frumenti..... 2½ ozs
M. Sig.: Tablespoonful every four hours.

# ABSTRACTS.

## THE CAUSES OF SHOULDER PRESENTATION.*

DR. SIGMAR STARK, CINCINNATI.

The author cited two cases of shoulder presentation in the same patient, the first proving uneventful owing to the prematurity of the child, but the second labor was attended with all the difficulty of this malposition. This was terminated by the delivery of a large child which could not be resuscitated.

Among the factors given as the cause of shoulder presentation, is the doctrine of Hippocrates and Aristotle which held sway for many years, that the fœtus sat upright with its back toward the spine of its mother until the seventh month, when it was either suddenly or very gradually rotated so as to assume the opposite position. Playfair considers a number of conditions as predisposing thereto, among them, prematurity of foetus; excess of liquor amnii; undue obliquity of the uterus; low attachment of placenta; irregularity in the shape of the uterine cavity. More common in multipara than in primipara; accidental causes exert most influence, as falls, or undue pressure exerted on the abdomen by badly fitting or tight stays.

Cazeaux and Tarnier add distortions of the superior strait to the above list. Flanging ilii are considered by some as predisposing factors, likewise the wrapping of the funis about the neck of the child, thereby interferring with the descent of the head. Shoulder presentation is also apt to occur in the second born in the case of twins, and is explained by the laxity of the uterine walls which is apt to exist under such circumstances.

I examined this patient twice with the pelvimeter and found the pelvic measurements normal. After version had been performed in the second confinement, the child, though an exceptionally large one, passed through the parturient canal and pelvis very readily, proving that there was no reduction in the size of the pelvic diameter.

I had hoped that the primary deformity of the uterus upon which Wigand and Danyan lay such stress would receive more consideration in the discussion. This observation has received support from such men as Siebold, Naegele, Schroeder and others. Cazeaux and Tarnier are skeptical on this point, however. Subsequent examination of the case presented failed to reveal any evidence of such condition.

* *Abstract of a paper read before the Obstetrical Society of Cincinnati.

### DISCUSSION.

DR. TAYLOR: I think where the malpositions recur in the same patient, it is almost a certain indication of malformation. And George Engleman, who has written more than any other American on prolapsus of the umbilical cord, traces that to malpositions, and that is almost equivalent to saying there is malposition otherwise, because if the head is all right the cord is not likely to be prolapsed, and so I believe deformity at the brim is more likely to be the cause. The others are undoubtedly true causes, as where there is hydrops amnii, or the presence of twins, there is likely to be malposition. I can recall three cases of shoulder presentation of the second child in cases of twins.

DR. STANTON: I have nothing to say upon this subject that will throw any light upon it. Dr. Stark has gone over the reasons now generally given for this presentation. I think, however, all obstetrical writers refer to the fact that transverse presentations are very often associated with pelvic deformities. The other conditions that favor shoulder or trunk presentations the doctor has referred to. One especially is the great enlargement of the uterus from hydrops amnii, which permits the child to lie in a transverse rather than an upright position. The reason for a frequent association of transverse presentations with pelvic deformities I am not able to explain, but I suppose one reason is the greater obliquity of the brim and the greater difficulty for the head to find entrance to the pelvis, giving lodgment to the shoulders. Also, in these women there are usually other deformities; they are short in stature and their abdomens are short. At least, it has been my experience; so far as I have

observed, cases of pelvic deformity usually occcur in persons of very short stature, whose abdomens are short but enlarged transversely. At the last meeting of this society which I attended, I reported a case of induced labor in a woman, who had had several children. I have referred to this case before and will call it to your minds now. The patient was a woman who had had eight children, all of which had presented by the shoulder except one. Seven of them where deliveries between six and a half and seven months.

DR. PALMER: I, too, cannot throw any light upon this question, but I can refer to my own immediate experience. I have no doubt all the conditions assigned in the causation of this trouble of parturition, exist, as mentioned by the different authorities, but, looking over my past experience, I am pretty well convinced that the pelvic deformity, mentioned by the last speaker, is the cause of most cases. In former years I had considerable obstetrical practice. The patients were mostly of German ancestry. I am pretty certain almost all, if not all, the shoulder presentations occurred in German woman who had a narrowing at the conjugate of the pelvic brim, from what I regarded at the time as the rachitic pelvis. It is easy to understand how a contraction at the pelvic brim, in its antero-posterior diameter, may obstruct a descent of the fœtal head into the pelvic cavity. We know there is a tendency for the head to fall into the pelvic cavity in primi-parous women because of the rigid condition of the abdominal walls, if the pelvis is of normal dimensions, when ordinarily in multiparous women it does not do so, because these walls are relaxed. A rachitic malformed pelvis prevents the normal descent of the presenting head, and the adjoining shoulder is forced down and made to present.

## A ZWANK'S PESSARY IMPACTED FOR NINE YEARS AND A HALF, CAUSING RECTO-VAGINAL FISTULA.

Dr. Ernest A. G. Steele reports a case of a woman, æt. 45, who applied at the Cottage Hospital, Plaistow, to have an "instrument" removed from the vagina. She said that ten years previously she had the instrument supplied by the Truss Society for a "falling of the womb." She never went to the Truss Society again, but six months afterwards a friend removed the instrument and replaced it, and it had never been touched since. For five years she has had pain and discharge, and during the last twelve months fæces have occasionally passed per vaginam. On examination, under an anæsthetic, the instrument was found to be a Zwank's metal pessary, which was firmly impacted in the vagina and the handles of which had cut their way into the rectum about one inch above the anus. The pessary was removed with some difficulty and the vagina was irrigated, when it was found that the fistula was about an inch in length. The edges of the fistula, which were much indurated, were pared and brought together with silk sutures. Three weeks afterward the fistula had healed except at its upper part.—*The Lancet*, 1893, p. 1059.

## A CASE OF TRANSPOSED VISCERA.

Dr. Frederic C. Coley reports a case of a boy, 15 years of age, who had frequently suffered from bronchitis, but when free from an attack of that kind had not complained of any shortness of breath on exertion. On examination the heart's impulse was found to be an inch below, and half an inch internal to the right nipple. The area of heart dullness was normal in extent, but transferred to the right side of the sternum. The liver dullness was absent from its usual position, but there was a corresponding dullness on the left side. The patient was unaware of the displacement of the heart until I pointed it out to him. He had suffered from nystagmus from infancy, and nyctalopia had long been complained of, *i. e.*, his sight was perfect in broad daylight, but he was almost blind in twilight or ordinary artificial light. He was rather small for his age, and there was no sign of puberty. He seemed fairly intelligent, but was said to be somewhat backward at school, though not more than was accounted for by his frequent absences on account of attacks of bronchitis.—*The Lancet*, '93, p. 1059.

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*January* 2, 1894.

[Stenographically Reported by C. C. Mapes, M. D.]

### PEDICULATED UTERINE FIBROID.

DR. W. H. WATHEN: This tumor is a pediculated uterine fibroid, twenty pounds in weight, which was attached to the fundus of the womb. The woman had suffered with the tumor for fifteen years; it gradually increased in size, and caused serious local disturbances; it had increased more rapidly during the last two years, and was causing so much pain from pressure, loss of flesh, etc., that she insisted upon having it removed. The tumor did not appear to be firmly connected with the uterus, and was diagnosticated as either an ovarian fibroid, or a pediculated fibroid of the uterus. Her urine was examined by the interne at the infirmary and pronounced normal, with the exception of the specific gravity being 1.030. It was examined at night and probably the examination was not reliable. The urine is always examined before I do a laparotomy. The examination is usually made by my chief assistant, Dr. Louis Frank. If there is any trouble with the kidneys I invariably ask the anæsthetist to give chloroform, believing it less injurious in its action upon the kidneys than ether. But if the kidneys are normal I leave the matter entirely with the anæsthetist, and he administers which ever he prefers. In this instance he began the anæsthesia with chloroform, but shortly afterward changed to ether, so that probably five-sixths of the time the patient was under the influence of the anæsthetic, it was by ether. When the abdomen was opened I observed that the tumor was a pediculated uterine fibroid. The omental adhesions, as can be readily seen, were very extensive, and I have never seen omental adhesions so tough. A large portion of the omentum was removed. There was nothing of special interest during the operation, with the exception that just after the adhesions were separated, Dr. Frank with his hand on the abdomen felt the aorta beating very rapidly, and said the woman's pulse was 130. It was normal before the operation. The operation was quickly completed. I examined her twenty minutes afterward and the pulse was 74. I saw her again at 5.30 in the afternoon, two hours after the operation, and at eight o'clock in the evening—pulse 80. She had passed some urine without catheterization. I saw her no more until eight o'clock the next morning, when her temperature was 102° F., pulse 120, urine scanty, passing about an ounce at a time every two hours. There was nothing in the operation that could induce such a condition. I did not suspect trouble with the kidneys, and thought possibly it might be one of those cases with an idiosyncrasy to the toxic effect of iodoform, as a great deal was sprinkled over the wound, though but little could have gotten into it. There was considerable oozing, and a drainage tube was used for seven hours. The iodoform was all removed, but when I returned at noon there was no abatement of the fever, and the pulse was more rapid. The quantity of urine gradually decreased, pulse a little more rapid and during the night ranged from 130 to 140, and the temperature 101° to 103° F. The next morning pulse still 140, urine decreasing in quantity, and after nine o'clock, no urine was passed and there was none in the bladder. There was but little change in the pulse until five o'clock in the afternoon, when it went up to 150 and then varied irregularly from 160 down to 135. She was unconscious until seven o'clock, when the pulse became imperceptible; she passed into a comatose condition about eight o'clock, dying two hours later. She had no convulsions.

There was not a symptom of sepsis; the gas passed freely and the abdomen was flat. The bandage had to be tightened several times, and when she died the abdomen was flatter than immediately after the operation. There was no iodoform poisoning, and nothing to account for the condition except the kidneys. I had the urine examined before her death by Dr. Frank, and append his report:

"*Mrs. D.—urinalysis.*
Amount for 24 hours, not stated.
Specific gravity, 1.030.
Reaction, acid.
Color, reddish brown.
Albumen, ⅛ by volume.
Sugar, none.
Urea, two per cent.
Uric acid and urates, abundant,
Blood, few corpuscles seen in some fields.
Pus cells, very few.
Epithelia, bladder abundant, few vaginal.
Casts, fatty, finely granular, hyaline."

You will observe that the specific gravity was still 1.030. I am convinced that the first

examination was imperfect, and that the woman had, because of pressure of the tumor upon the kidneys, chronic nephritis, and that the ether had acted as an irritant and had brought about a suppression of urine, probably by causing acute hyperæmia.

I report this case because there are not many such cases reported where death has resulted from either chloroform or ether—more frequently of course from ether, although there are some cases reportcd of death caused from suppression of urine from chloroform. I believe that there are more deaths from the effects of ether upon the kidneys than have been reported. Some operators may not feel that such cases are worth reporting; some may not have observed carefully to discover what the trouble was; and some through carelessness may not care anything about reporting them. I make this report to emphasize the significance of carefully examining the urine in all patients where we are going to give ether, and particularly so in abdominal surgery where there is a large cystic tumor, or hard tumor that by pressure upon the kidneys may have caused nephritis. Relatively there are more deaths from ether following operations for fibroid or solid tumors. I have the urine examined in every case to be operated upon, even for curetting the uterus or for a vaginal operation, before the anæsthetic is given, but I will not give ether again until the urine has been examined by a *thoroughly* competent person. While I might have no trouble in many cases, I believe our patients are entitled to this protection.

DISCUSSION

DR. J. W. IRWIN: The case reported by Dr. Wathen is a very remarkable one. I do not care to have anything to say in regard to the surgery or surgical proceedure, but if this was a case of chronic nephritis as the Doctor says, it is very strange indeed that some evidence of nephritis was not present prior to the operation. The specific gravity of the urine following the operation would not correspond in my judgment to a case of chronic nephritis, and neither would hyaline casts, and as there had been no convulsions and no conditions leading to a semi-comatose state, it would be very hard to understand how chronic nephritis could have been in existence, that terminated in death so suddenly after the administration of ether. I do not quite understand how pressure of this tumor upon the kidneys, protected as they are, could have brought about the condition as stated. It is true that tumors may have some influence bringing on disease of the kidneys, but I do not think it is due to the pressure of the tumor. I cannot conceive how a uterine tumor like the one exhibited, could press upon the kidneys, especially a tumor connected with a movable organ like the uterus. The very fact that this patient lived after the operation without going into a comatose condition until she was moribund, and the further fact that examination of the urine showed the specific gravity to be 1.030, with hyaline casts—anyone competent or not might be able to take the specific gravity of urine—leaves this in my mind an open question as to whether chronic nephritis ever existed, or, indeed, any form of nephritis, prior to the operation. It seems to me that the condition which ended in death must have been due to the operation, either to the ether or shock; or it was due to some disturbance produced in the nervous system that brought about the fatal result. The imperfect report of the case hardly admits of discussion. The last urine examined by the chemist seems to throw no light upon the nature of the trouble, and where or when it was obtained from the patient, I do not understand, as "No urine was passed (for thirteen hours before her death) after nine o'clock (A. M.) and there was none in the bladder." It may have been a case of acute nephritis, but this is merely conjecture.

DR. J. A. OUCHTERLONY: The report of the case is defective in one respect, namely, that it does not state what was the character of the casts. A great deal depends upon that. If the casts were of a character that would indicate chronic nephritis, of course, it alters the case. Simple hyperæmia of the kidney does not give rise to a temperature of 103° F.

DR. W. H. WATHEN; The report by Dr. Frank, plainly states, "Fatty, finely granular, hyaline casts." It is usual in cases that have died from ether, where the ether has acted as an irritant upon the kidneys, that there have been no convulsions, and the patients have gone within a few hours of death before entering into a comatose condition. This is true in nearly every case reported. I suggested that probably this patient had acute hyperæmia of the kidneys, the result of ether acting upon either healthy or previously diseased kidneys. There are two forms of renal hyperæmia, one active the other passive. In the active form the arterioles are dilated; in the passive form there is venous dilatation. In the passive form there will, of course, be no fever, but in the active form you may have a temperature ranging from normal to 103° F., with the character of pulse that I have described, and with the same condition, going into coma and death. This is the history of acute hyperæmia of the kidneys in many cases. Dr. Frank's statement, which I file as a part of this report, would indicate that there had been previous trouble in the kidneys; further, that this patient had hyperæmia of the kidneys, because there were blood casts, and other characteristic condi-

tions of hyperæmia. There is one thing certain, the kidneys caused the trouble, and there was no surgical shock after the operation. The pulse went down to 74, and remained under 85 for ten hours after operation, then rose progressively until death. The temperature ranging from 101° F. to 103° F. The kidneys are not protected as Dr. Irwin suggests, from pressure, but may be badly injured by the pressure of a fibroid tumor of the uterus, or any solid, or even cystic tumor in the abdominal cavity.

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TRACHEOTOMY FOR REMOVAL OF A BUTTON.

DR. W. O. ROBERTS: One week ago last Wednesday I operated upon a case that was referred to me by Dr. Ray. A child thirteen years of age, the Thursday preceding, had a button between her teeth whistling through it, when by some means it was sucked into the throat, and passed down into the air passages. She was brought to the city the following Tuesday. Dr. Ray made an examination and when she would cough the button would come up into the larynx, sometimes almost entirely shutting off breathing. The button could be plainly seen in the larynx, but could not be grasped. The case was referred to me, and I operated at the Norton Infirmary. Drs. McMurtry, Ray and a number of others being present. Just as the child was going under chloroform, she had a coughing spell, then it seemed to me she had ceased breathing. I made a free opening in the trachea, dividing about four rings, then she coughed a number of times and the trachea seemed to be perfectly free. I opened the wound well and looked up into the larynx, and there was the button which was easily and quickly removed by grasping with forceps. I then closed the wound by passing a suture through the integument and tissues down to the trachea, bringing them together excepting a small point at the lower angle, applying the usual dressing. Absolutely no trouble followed the operation, and on Friday afternoon I removed the sutures; the wound seemed to have perfectly healed, and she went home feeling comparatively well, the operation having been performed on the preceding Wednesday. I have heard from the patient since, and there has been no trouble whatever. The button, which I exhibit, you will see is about three-quarters of an inch in length by one-quarter inch in width.

DISCUSSION.

DR. L. S. MCMURTRY: The case had one very instructive point that Dr. Roberts has brought out, which will bear emphasizing. There was marked disturbance of the respiration when the button was forced up into the larynx and lodged there. It would have been very easy to have overlooked it.

DR. A. M. VANCE: I would like to ask if treatment by inversion had been used in the case reported before operation?

DR. W. O. ROBERTS: No.

DR. J. A. OUCHTERLONY: The case reminds me of a very interesting historical fact: Stephenson, the father of Railways, on one occasion swallowed a sovereign, and with the mechanical ingenuity for which he was celebrated, it occurred to him that he might bring the force of gravitation to bear upon his case in a favorable manner; so an inclined plane was constructed by which he had himself inverted, and sure enough the weight of the gold piece caused it to come down, and all of a sudden it was expelled. He remarked that when he heard the jingling of the gold piece upon the floor he thought it the "Sweetest sound he had ever listened to." I no not suppose anything of the kind would have been practicable in this case.

DR. L. S. MCMURTRY: This occurs sometimes: I remember operating once in the case of a boy who had gotten half of a shell-bark hickory nut hull in the trachea, which had been there for a month. I did a tracheotomy; the usual coughing occurred when the wind-pipe was opened. The foreign body did not present, and I put in a tracheotomy tube. On the fourth day the foreign body was expelled through the larynx, coughed up in a fit of coughing. In coughing, of course, the tube was thrown out, and then the foreign body was also expelled. On investigating the literature I found a number of cases reported where it was believed that opening the wind-pipe was beneficial in enabling the patient to throw out the foreign body. I would like to inquire what has been the experience of the members in this direction.

DR. WM. CHEATHAM: I believe it is a very bad method to insert the tube in these cases. In doing this you have done away with the safety of the tracheotomy. If the wound is held open with sutures, the chances are very much better for getting the foreign body out. I am positive that the tube is not indicated in cases of foreign body in the trachea.

DR. J. A. OUCHTERLONY: One danger in laryngotomy and tracheotomy occurs to me in connection with this case: Not many years ago a friend of mine was called in to see a patient who suffered from paroxysmal attacks of difficulty in breathing, and this gentleman made a diagnosis of tumor of the larynx, and suggested the propriety of an operation. I explained the matter to the family, and inasmuch as he was in frequent danger of suffocation every day and his sufferings were intense, they consented. I gave the patient chloroform, and my friend made an incision through the cricoid and trachea and proceeded to insert a tube. In doing so

the patient ceased breathing. The operator ceased momentarily, and again proceeded to insert the tube, and with considerable more effort, when the patient ceased breathing for good. When an autopsy was made it was found that the soft structures lining the trachea had not been pierced by the knife, and when the tube was pushed in the membrane was pushed before it effectually shutting off the patient's wind. No tumor was found.

DR. W. O. ROBERTS: I have not much to say in closing the discussion: I want to mention a case that I operated upon some time ago, and possibly may have mentioned to this Society:—A child had gotten a shoe-button down into the wind-pipe, and every effort was made to get it expelled without operation. Inversion was used several times without effect. Operative interference was finally determined upon, and as the child was going under the anæsthetic, in fact had gotten pretty well under its influence, there was a violent paroxysm of coughing, the child becoming perfectly blue in the face. When this condition had passed off anæsthetic was resumed, and after it was thoroughly anæsthetized the trachea was opened and held open for quite a while, the child was inverted slapped on the back, etc., still no foreign body came out. The wound was then stitched open, and no tube or anything else put in. I saw the child the next day twice, and no foreign body had escaped. On the second day after the operation I visited the patient again, and found that the button had been passed by the bowel. I am satisfied that this child coughed up the button and the relaxing effect of chloroform upon the muscles of the larynx allowed it to come out and it was then swallowed.

I think one cause of failure in operations of this kind is due to the fact that the opening in the trachea is not made large enough; that is, the incision is too small for the foreign body to get out. One of the first operations of the kind I ever did was for the removal of a cockle burr. I opened the trachea but the foreign body was not coughed out. I then put in two hooks to hold the wound open; these hooks were what is known as the "double-hook" and fastened around the neck. The following day the child had a violent paroxysm of coughing, strangling for breath and pulled the hooks out. In a very short time it was dead. I made a *post mortem* examination, and found the foreign body, (cockle-burr) in the larynx, completely closing it. I suppose the child was not able to get any air from the opening in the trachea and suffocated. In that case I believe if the opening in the trachea had been sufficiently large, or had been stitched open, the foreign body would have been coughed out. After the result in that case I determined never to use an instrument of any kind or description again in the trachial wound, but passed two sutures through either lip of it, one above and one below, and tie them around the neck so as to have a good free opening. Since then I have done quite a number of these operations and the patients have all gotten well. One was a very remarkable case in a child at Owensboro, Ky., who had swallowed a tin whistle. I made a free opening in the trachea, and tried every way after the opening was made to have the foreign body expelled. I passed a pair of forceps down into the trachea thinking possibly I might grasp it; but failed. On the third or fourth day the child had a paroxysm of coughing, raised up in bed, and the foreign body flew across the room.

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Dr. P. Guntermann read the essay of the evening

## A CASE OF ERYSIPELAS.

(See page 312)

### DISCUSSION

DR. WM. CHEATHAM: I do not agree with the essayist that the diagnosis of erysipelis is always very easily made. I have seen a great many cases, where there was an abcess of the tear sac which had been diagnosed as erysipelas. My experience has been that it is quite common for physicians to make diagnosis of erysipelas in abscess of the tear sac, when there is no erysipelas.

DR. C. G. LUCAS: I remember about two years ago I had a case of erysipelas involving the left forearm and part of the arm, and in the treatment I used gauze saturated with 1 to 500 bichloride of mercury. In addition to that I had read somewhere, that where you have erysipelas, particularly of the extremities, by passing an adhesive plaster upon each edge it might be confined. I tried the plaster in this case and found it succeeded very well. It seems to me that some persons are peculiarly susceptible to erysipelas.

DR. A. M. VANCE: I have had a great many cases of erysipelas to treat, and have found that the use of the alimentary canal as a drain to the general system acts as a valuable aid in keeping down the high temperature, also seeming to aid in the rapid cure of the disease; therefore, I have been in the habit of giving salines with considerable regularity. I have always used whiskey internally, and locally I use glycerine and carbolic acid. This applied often, every day, I have found in most cases to arrest the spread of the inflammation, seemingly to absorb it, and keep it within its bounds. I use a small amount of carbolic acid in glycerine, not more than one part in one-hundred, and apply it on antiseptic gauze. It seems that the affinity gly-

cerine has for water deprives the tissue of fluid, and in that way bleaches them, making it a valuable antiphlogistic locally. I believe if there is a specific for erysipelas, we have it in carbolic acid. I do not think I have ever seen a case of erysipelas die, and I have had a great many. In my experience for the last ten years I have noticed how seldom we see erysipelas following wounds that we make. It is an uncommon thing, I believe now, to have a case of erysipelas in wounds made by the surgeon, while years ago such cases were not in infrequent. This is evidently entirely due to the proper cleansing and preparation of the patient beforehand.

DR. J. M. KRIM: I have a number of cases of erysipelas convalescing now. As far as the antipyretic treatment is concerned, I do not believe it does any good. Like Dr. A. M. Vance I think we can get better results by letting the alimentary canal do the work. The administration of salines in my experience has done the most good of any internal medication. As to local treatment, I believe that carbolic acid is the next thing to a specific, although I have had very good results during the last year or two with a preparation called campho-phenic. It is more soothing than carbolic acid alone. The preparation consists of a combination of carbolic acid and camphor. I use with it an equal proportion of liquid alvoline, so as to prevent the too frequent application. Used in these proportions, and applied with a sponge or with anything soft, application will not be necessary more than once every two hours, but with carbolic acid and water it would be necessary to make more frequent applications. It protects the skin and prevents the itching which is characteristic of erysipelatous conditions. Constitutional treatment I do not think amounts to anything as far as superficial erysipelas is concerned. Where there is a phlegmonous condition, of course that requires constitutional treatment; but salines are always indicated.

I want to refer to a couple of cases where the patients had hay fever, and contracting erysipelas it seemed to destroy that condition which had previously existed. I have observed this in two cases that as soon as erysipelas developed there was a disappearance of the hay fever. One case is just convalescing now. I saw him in the first attack two years ago; he was a periodical sufferer with hay fever and was compelled to leave town. After taking erysipelas he had no further trouble with hay fever, and has another attack of erysipelas from which he is just convalescing. I believe that erysipelas may have some effect upon doing away with hay fever.

DR. J. A. OUCHTERLONY: I am very much gratified having listened to my friend Dr. Guntermann's paper; it is exceedingly practical and to the point, and brings up a number of interesting, practical thoughts. In the first place, as to the classification of the disease. Of course we are all aware that there is hardly any disease which presents itself under more numerous aspects than erysipelas. So much so that one is often tempted to ask whether an individual case really is entitled to be considered as erysipelatous in its nature. The variety alluded to by Dr. Guntermann "Erysipelas Fugax," I can hardly believe to be a genuine erysipelas. This variety is described by older dermatologists as "erythema fugax" which comes suddenly and goes as quickly as it came, and while disappearing and as long as it lasts, is lacking in the chief characteristics of an infectious disease. The cause of erysipelas has been considered to be independent of micro-organisms, but I do not think it is. Most recent observations tend to show that it is due to the streptococcus pyogenes aureus. The fatal termination that is so likely to occur in persons of advanced age is also observed in subjects of a very tender age. That is an important practical point. I do not think that in erysipelas occurring in the first two weeks of life the patient ever gets well. At least that is the general impression, and I am sure in my own practice I have never known of a case of infantile erysipelas occurring during the first two weeks, that terminated in recovery.

As to treatment, I am reminded by the remarks of my friend Dr. Vance of a practice that prevailed many years ago in the Demilt Infirmary, New York, introduced by Dr. Sayre. His rule was in cases of erysipelas of the lower extremities, which was the most common seat of the trouble in the laboring class that constitute the patients of that Infirmary, to make a free incision from the knee down to the ankle, and then to administer drastic purgatives. The rule was to make one long, deep incision, then give the patient a dose of calomel; 10 gr. calomel and 20 gr. jalap. The treatment that I have generally adopted has been identical in principle with the saline treatment mentioned by Dr. Vance. I generally use a simple protective with carbolic acid; benzoinated oxide of zinc ointment is a very serviceable preparation in this affection.

It is said that the micro-organisms of erysipelas are found in greatest abundance in the periphery of the erysipelatous area; that in the center there are comparatively few, but at that point where the disease is extending the streptococci are found in greatest abundance. And I suppose it is for that reason that injections at those points have been made of sulpho-carbonate of zinc and other like substance with a view of destroying the septic

agents and preventing the extension of the disease.

DR. W. H. WATHEN: I would like to inquire if any of the members have had experience in treating a case of delivery at term, or premature, in patients suffering with erysipelas, and if so has there been any puerperal trouble following? The same micro-organisms are said to be found in these two conditions.

DR. J. M. KRIM: Four or five months ago I saw a case of erysipelas which was quite extensive, in a patient at about the fifth month of pregnancy. This patient aborted, but there was no puerperal trouble following. I think the abortion was due, however, to the erysipelatous condition.

DR. W. H. WATHEN: I saw in consultation about two years ago, a case of labor where the woman had a severe attack of facial erysipelas, with rapid pulse and high temperature, which caused premature labor at about the eighth month. The attending physician observed every aseptic and antiseptic precaution known in such cases, and the woman had no puerperal trouble whatever, making a prompt and easy recovery.

DR. P. F. BARBOUR: Several references have been made to the antagonism of different micro-organisms: I noticed in a recent issue of the *Therapeutic Gazette*, a report of the case of a young girl who had gonorrhœa and developed erysipelas of the thigh, when it was observed that the gonorrhœal infection immediately subsided, and there was no return of the trouble.

DR. J. M. KRIM: I recently saw a child about six months old that had a discharge from the vagina. Owing to the *pecularities* of the mother, I said nothing about the character of the discharge, nor did I know at first. On the second day I saw the child again, when the discharge was very charateristic and profuse. On the fourth day erysipelas developed, and an examination of the vagina showed that the discharge had almost entirely ceased. However, I instructed that the parts to be douched and on the following day there was no discharge whatever. I hardly think the erysipelatous attack could have stopped the discharge so quickly, but the erysipelas was certainly very well-marked.

DR. P. GUNTERMANN: I agree with Dr. Cheatham that abscesses of the face, particularly about the eye, and swellings coming on from gum-boils or something like that, are very frequently mistaken for erysipelas.

I do not believe that in all cases purgation is the treatment. I think, however, that it is always well to pay close attention to the bowels and kidneys.

As to erysipelas fugax: I simply inserted the word "fugax" in parenthesis in my paper, and did not intend it as a classification.

I believe that a simple dry application is very much better than any wet application, at any rate that has been my experience. Also in a great many cases I have treated, I never succeeded until I perfectly saturated them with an iron preparation. I used tincture of iron *neutralized*, because it makes a fairly pleasant drink diluted with water.

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### CASE OF RHEUMATISM WITHOUT HISTORY OF TRAUMATISM OR CONSTITUTIONAL TAINT.

DR. J. W. IRWIN: A lady, twenty-eight years of age, is under my care; she is the mother of three children in a perfect healthy state, with good history, no consumption, no scrofula and no syphilis. Evidence of syphilis were absent in the children, also in the husband and in herself. She was taken with an attack of rheumatism affecting the right knee and the right wrist. Pain was very severe, especially in the knee. There was no history of constitutional disease, neither had she been accustomed to hard work or scrubbing. I was called to see the case after it had been treated ten days. There was a great amount of swelling at the knee joint, surrounding the the entire joint—especially about the patella. On the outer side of the patella, parallel with the joint, pain was very intense. I suspected an abscess had formed, and employed exploratory measures which discovered pus. The abscess was opened and discharged I believe about a pint of pus. It is the first case of the kind I have ever seen without any history of traumatism, or the result of constitutional taint. I would like to know if the Fellows have met with such cases, or if such cases are at all common.

#### DISCUSSION.

DR. J. M. KRIM: I saw one case some time ago in a man who had gonnorrhœa, both knee joints being affected. One was not very painful and was not opened. The other was intensely painful; an abscess had formed which was opened and about a half pint of pus evacuated. I believe that it was the result of the gonorrhœal trouble. While this condition of swelling, pain, etc. was going on, there was no discharge from the penis, but after he obtained relief from the rheumatism, the discharge came on again from the penis; it was more modified than it had been originally, but still continued.

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### ACUTE ŒDEMA OF THE LARYNX—INTUBATION.

DR. WM. CHEATHAM: A man, fifty-nine years old, was brought to my clinic the other day during my absence, and was sent around to my office. He suffered very great difficulty in breathing. I was busy at the office, but as

it was an urgent case I saw him at once and found it to be one of acute œdema of the upper part of the larynx and referred the case to Dr. Dugan who was at that time holding his clinic at the College. There was a very large cicatrix of the pharynx which indicated to me that the patient had had syphilis, which proved true. Dr. Dugan did a tracheotomy to relieve the difficult breathing; after the patient recovered from the anæsthetic he walked home. The second day afterward I went to see him and found his breathing very difficult, although the trachial wound was opened. I had a small tracheotomy tube with me, and inserted it, but it did not seem to afford any relief. I then decided to do an intubation, but there was some danger in this procedure, on account of the œdema; I feared it might overlap the intubation tube and cover the opening. I took the largest size tube use for intubation purposes, and inserted it without any trouble until it came in contact with the tracheotomy tube, when, of course, it would not go any further. I removed the tracheotomy tube and could then see the intubation tube through the wound in the trachea. As it was a very long tube it extended some distance below the trachial wound. The patients has had no trouble in breathing since; the trachial wound has about closed, no sutures were used. I have had to scarify the œdematous part two or three times, and it is gradually decreasing in size under this scarification, inunctions of mercury and iodide of potassium in progressively increasing doses.

At first I was afraid it was not a case for intubation, on account of the œdema of the throat, fearing as I stated before it might overlap the head of the tube and in that way cut off breathing. But it was perfectly successful.

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EHRLICH'S TEST.

DR. J. A. OUCHTERLONY: We are all quite familiar with the fact that the diagnosis of typhoid fever in the early stages is often a matter of difficulty, and for that reason, anything that tends to enable us to make a positive diagnosis in the early stage of the disease, must be of value. In this connection I wish to call attention of the Society to what doubtless you are all familiar with, namely Ehrlich's Test. It never responds save in typhoid fever and in acute miliary tuberculosis, and in some acute inflammations. Acute miliary tuberculosis is usually easy enough of diagnosis. Inflammatory affections are attended with such very characteristic symptoms and physical signs, that there is no difficulty in recognizing them. But typhoid fever is sometimes obscure in its beginnings. Of late I have made use of the Test in a number of cases, and it so happened that they all developed under such circumstances as to make the diagnosis obscure, and but for this test I would have been unable to make a positive diagnosis until several days later.

The test is as follows:

1. Saturated solution of sulphanilic aicd in a solution of 50 c. c. to 1000 c. c.

2. A ½ per cent. solution of sodium nitrite.

A quantity of urine is placed in a test-tube with an equal quantity of a mixture of solution of the sulphanilic acid 40 c. c. and the sodium nitrite 1 c. c. the whole being thoroughly shaken. One cubic centimeter of aqua ammonia is then allowed to flow gradually down the side of the tube forming a colorless zone above the yellow urine, and at the junction of the two a deep, brownish red ring will be seen, if the reaction is present. With normal urine a lighter brownish ring is produced without a shade of red.

The color of the foam of the mixed urine and reagent and the tint they produce when largely diluted with water, are characteristic, being in both cases of a delicate rose-red if the diazo-reaction be present, but if not, brownish yellow.

It may be present before the rash appears, on the sixth day, and has been found as late as the twenty-second.

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### Chrysarobin in Psoriasis.

The London correspondent of the *Bulletin of Pharmacy* says: "The dirty and unpleasant character of chrysarobin ointment is well known. The extent to which it stains the clothes frequently causes the patient to object to a thorough treatment with this medicament in psoriasis. Dr. Dale James finds that chrysarobin can be applied with more cleanliness by dissolving 1 part chryarobins in 7 parts of chloroform, and stirring about an equal quantity of soft petroleum into the mass. The preparation is applied to the psoriatic area with a brush."

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### La Grippe.

℞
Benzoate sodium..... ½ oz
Glycerine..... 1 oz
Liq Tong. Sal.... ..... 3 ozs
Aqua Mentha pip ..... 2 ozs
M. Sig.: Tablespoonful every two to four hours.

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### Diuretic and Rheumatic.

℞
Lithium salicylate..... 2 drms
Liq. Tong. Sal..... 3 ozs
Glycerine..... 1 oz
Aqua Mentha pip.. ..... 2 ozs
M. Sig.: Two teaspoonfuls every two hours.

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### Malarial Neuralgia.

℞
Acetanylid..... 4 drms
Liq. Tong. Sal..... 8 ozs
M. ft. sol. Sig.: Teaspoonful every four hours.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE MEDICAL CHRONICLE OF MANCHESTER ENGLAND.

for February contains an article by Dr. Roger Williams on

**Sarcoma of The Breast.**

The author shows that the relative liability of the female breast to sarcomatous growths is much below the average for the body in general; 9.4 per cent. of the body neoplasms being sarcomatous, whereas only 3.9 per cent. of female breast neoplasms are of this nature. The feature, that, more than any other, has arrested his attention in connection with this disease is the great rarity of its occurrence, as compared with cancer.

The great majority of mammary sarcomas arise in the immediate vicinity of the small ducts (adeno-sarcomas); only rarely do they originate elsewhere (pure sarcomas). This is the more remarkable when we recollect the great abundance of fibro-adipose tissue that goes to make up the breast, which elsewhere is such a favorite starting-point for these growths. Moreover, the mammary integument enjoys even more complete exception from sarcoma than it does from carcinoma; with the exception of a few rare cases of keloid, the author knows of hardly any other instances of sarcoma thus arising. These facts seem to indicate that the abnormal post-embryonic developmental changes, whence the disease originates, are the outcome of abnormal functional activity. The matrix tissue of the initial proliferative changes usually is the layer of hyaline substance immediately surrounding the epithelial investment of the small ducts, which has been shown to be a myxomatous modification of the adjacent connective tissue, consisting of a network of flattened, branching, nucleated cells, embedded in hyaline stroma. Owing to the intimate relationship thus subsisting between the glandular and connective tissue elements, both are usually involved in sarcomatous neoplasms of this part.

The author believes that the glandular structures met with under these circumstances are of neoplastic origin, rather than the outcome of mechanical distortion of pre-existing structures, from the fact that they have often been found within intra-cystic growths several inches long. Nevertheless, it seems certain that these grandular structures do not form an essential element of the disease. The term adeno-sarcoma, given by Billroth to growths thus constituted, is however a good one, and it certainly ought to be retained.

In regard to adeno-sarcomas of the breast, the author's observations would lead him to the conclusion that they are of much commoner occurrence than pure sarcomas, in the proportion of about 80 per cent of the former to 20 per cent. of the latter.

With regard to the treatment, the whole breast, together with the tumor and the overlying skin, should be freely removed in every case at the earliest possible date. Unless the tumor is situated altogether on the anterior aspect of the gland, the fibrous sheath of the pectoral miscle should also be removed with it. Simple enucleation of the tumor must be condemned as an unscientific procedure. After extirpation of the diseased part it is a good practice to wash the wound with a strong solution of chloride of zinc (20 to 40 grains to the ounce). In doing this operation care must be taken to completely remove the axillary mammary processes. When enlarged lymph glands are present the axilla should be cleared, just as is done for cancer.

With regard to the after results, recurrences rarely supervene later than four years after the primary operation. Those, therefore, who survive free from return of the disease after this period may be regarded as cured. Recurrent growths, when operated, should be freely excised as soon as noticed. This practice not only prolongs life, but in many cases, after repeated operations, it has at length resulted in radical cure.

The statistical part of the paper is very full and the social state of the cases which have come under the author's observation is carefully noted, as is also the occurrence of pregnancy and the family history in regard to the occurrence of malignancy in any member of the family. The paper will be continued in the next issue of the journal.

Dr. Frederick Cox reports a "Case of Chronic Tympanic Disease with Marked Irritability to Treatment." The case is distinguished from the general run of such cases by the marked intolerance of medical treatment, and the temporary improvement of hearing power which was produced by an acute purulent tympanitis occurring while under observation.

Dr. Graham Steell reports a "Case of Cirrhosis of the Liver Complicated with Ulcerative Endocarditis."

THE CHICAGO MEDICAL RECORDER

for January contains a paper by Dr. Boerne Bettman, entitled

**Subvolution—A New Pterygium Operation.**

During the last six years the author has followed the method advised with good results. The underlying principle of the procedure is to prevent readhesion by placing a mucous surface in contact with a raw one. To do this he turns the triangular flap underneath, which action can best be described by the term subvolution (turning under). In order to carry out this rule he performs the operation in the following manner:

The pterygium is gathered up by the two branches of a fine forceps serrated at the ends. A knife is passed underneath it close to the cornea, and the triangular membrane is dissected off toward the apex. A suture with a needle at each end is passed through the

apex. Both needles are inserted from above downward, thus leaving a loop of thread on its outer surface. The needles are now passed through the base from below outward. The points of puncture being the ends of parallel lines drawn from the punctures in the apex and just far enough back so that when the flap is turned upon itself underneath the base, the role will correspond with the corneo scleral margin.

The two ends of the suture are now firmly tied, which induces a condition similar to gumming the flap of an envelope to its body. The under surface of the pteryglum is brought in contact almost throughout its entire extent, and adheres. A readhesion to the cornea is prevented by the role of mucous membrane at the corneo scleral margin.

The only seeming drawback to this procedure is the temporary unsightly thickening produced by the folding. This, however, disappears in a few days, and after a week or two flattens and settles down to the niveau of the adjacent parts of the eyeball. It adheres to the sclerotic.

The raw surface of the cornea is covered with scar tissue and regenerated epithelium.

No matter how much the base of the pterygium contracts after dissection from the cornea, sufficient allowance can always be made by stitching the apex more or less forward.

The apex may be cut off, or not, depending entirely upon the degree of thickness. It is hardly necessary to state that the eye is bandaged and cleaned daily with a boric solution, and that the thread is removed after two or three days.

The operation is especially indicated in large pterygia. Even in smaller ones, where the growth contracts considerably after having been separated from the cornea, it is followed often by good results.

In these cases adhesions will form, which will draw the turned flaps over the sclerotic up to the corneo scleral margin.

John A. Wesener, Ph. C. discusses

**The Clinical Significance of Peptonuria.**

He regards the subject as of the greatest importance, not only from the standpoint of the medical practitioner at lage, but from that of the surgeon, for it is often difficult to diagnose an abscess of any one of the internal organs and the detection of the presence of peptone in the urine goes far to warrant a diagnosis of this kind, its presence usually indicating that suppurative changes are in progress in some part of the system, the diagnostician having carefully excluded all other known causes. The author gives the following tests for peptone:

*Tests for Peptone.* If the urine contains albumen or mucin, it must first be removed. Albumen is removed as follows: to 50 c. c. of urine, add 10 c. c. of a saturated solution of sodium acetate and then a concentrated solution of ferric chloride, until a deep red color is produced. Potassium hydrate is now added, drop by drop, until neutral, then boil and filter; test a portion of the filtrate for albumen. Apply the acetic acid and potassium ferro cyanide test. If albumen is found, the filtrate must then be treated again with a little sodium acetate and ferric chloride solution, boiled and filtered. This is repeated until the test for albumen given above fails to react. the remaining filtrate, having been allowed to cool is then treated for peptone by adding a few drops of sodium hydrate and two or three drops of cupric sulphate; this gives a purple color if peptone is present and is known as the biuret test. A saturated solution of tannic acid gives a good reaction with peptone, but does not show traces that will be shown by the biuret test, and should any of the iron be left in the filtrate, it will form with tannic acid, the tannate of iron, which would obscure any precipitate formed. The removal of albumen by this method has the advantage of also removing the greater part of the coloring matter from the urine.

Devoto recommends the precipitation of albumen with crystals of ammonium sulphate. This takes more time and, as regards the urine, has no advantage over the method given. If peptone is tested for in the blood or visceral fluids, Devoto's method should be used as the results are more accurate.

Albuminous urine which has decomposed cannot be tested for peptone, as some of the albumen has been converted into peptone, and would give a reaction which would be of no clinical value, even though the albumen has been removed. This also applies to decomposed nonalbuminous urine, since bacteria have an albuminous structure peculiar to themselves which will react unless removed.

Urine containing mucin appreciable with acetic acid must be removed. To 20 c. c. of urine add just enough lead acetate solution to produce a flocculent precipitate, an excess must be avoided; filter and test filtrate for peptone, using the biuret test. A simple method of making a quantitative estimation for peptone is as follows: To 10 c. c. of urine apply the biuret reaction; then dissolve a known quantity of peptone in 10 c. c. of normal urine and apply the biuret test. Repeat the last operation until the colors are identical. Having a known strength of peptone solution for comparison this will give you the amount of peptone in the urine. The author has found this to be satisfactory and simple. Where albumin and mucin are absent the biuret or tannic acid test can be proceeded with without the preliminary steps. The author states that in inflammation and the production of pus from bacterial action, peptone is always present in the urine. The paper includes a brief report of several cases.

Dr. W. K. Jaques discusses

**The Operative Treatment of Diphtheritic Laryngeal Stenosis.**

He argues that the treatment of diphtheria, operative or otherwise should be:

First, to neutralize the poison, and to confine the disease if possible, to the primary seat of inoculation.

Second, to support the vitality of the patient, and prevent the ajoining respiratory

passages from becoming susceptible. That operation and medication should be selected which will best admit of carrying out these principles.

In malignant diphtheria, where the primary seat of inoculation has been in the upper respiratory passages and stenosis is secondary, tracheotomy is the best operation. The reasons for this are:

First, the air enters the respiratory passages below the disease and goes into the lungs pure, making auto-infection less likely.

Second, the pharynx and naso-pharynx can be better cleansed than if an intubation tube is in the throat.

Third, in this class of intubation cases, feeding is very difficult, but in tracheotomy it can be done quite well by passing a catheter through the nose.

Fourth, rest is a most important thing in the treatment of inflammation; and not a small item in favor of tracheotomy is that the diseased parts are at rest.

If intubation is performed upon such a case, even by the most skillful operator, the parts are likely to be lacerated; the tube will cause more or less irritation or coughing; the gasping draws poison-ladened air into the lungs, already made more or less susceptible by the labored respiration, and the condition known as "cut-throat" lung is the result.

A large majority of cases of laryngeal stenosis die from the spreading of the disease downward, and in every case that operation and treatment should be selected which will render this the least likely.

When we have reasons to believe that there is loose membrane in the trachea, tracheotomy is considered by many as safest for the following reasons:

First, during the insertion of the tube in intubation, the membrane may become detached, and be pushed in front of the tube; this danger, however, has been over estimated.

Second, the membrane may become loose, and act as a valve over the end of the tube, allowing the air to enter but not to escape, thus causing the chest to become barrel-shaped.

Stenosis caused by or following scarlet fever is best treated by tracheotomy.

In regard to the tube in tracheotomy, the author prefers the Durham tube on account of its shorter curve and jointed inner tube, which, therefore, has a less tendency to produce ulceration of the posterior wall of the trachea from pressure. The objection to this tube, however, is that it is too large and cumbersome. The author has prevented the backward pressure in the ordinary tubes by putting a rubber diaphragm over the retaining piece and slipping it back as far as the tissues would permit. This grasps the tube firmly, at the same time giving it all the movement required.

Every city should have a diphtheria hospital. This, as well as other contagious diseases, should be placed directly in the care of the health department. Isolation should be demanded, and when people are poor and living in a manner that this is impossible, the sick should be removed to a hospital where they would not be a source of danger to others.

The author concludes his interesting paper with the following brief and convenient summary of the cases suitable for operation:

*Intubation.*

First. Stenosis, from primary laryngeal diphtheria.
Second. Non-membraneous laryngitis.
Third. All cases under two years of age.
Fourth. Stenosis from measles.
Fifth. All cases in which tracheotomy is refused and intubation permitted.

*Tracheotomy.*

First. Secondary stenosis in malignant diphtheria.
Second. When there is membrane in the trachea.
Third. Stenosis in scarlet fever.

Dr. F. E. Waxham contributes "A Plea for the Early Climatic Treatment of Pulmonary Tuberculosis." The author urges that cases to receive the greatest benefit from climatic treatment should be sent early while the disease is in its incipiency. These cases must seek a change of climate as a first resort and not as "a last resort" after other methods of treatment have been tried and failed. As soon as the patient shows signs of tuberculosis he should at once be directed where to find almost certain relief. No delay should be sanctioned or encouraged in the vain hope that other lines of treatment may give relief.

There are two classes that should permanently occupy Southwestern Texas, New Mexico, Arizona, Colorado and Utah, and largely constitute the population, those with incipient tuberculosis, and those predisposed to the disease by heredity.

Dr. D. A. K. Steele presents the "Report of a Case of Cerebral Tumor, Diagnosed by Focal Symptoms, with Operation, Successful Removal of the Tumor."

Examination showed motor paralysis and sensory blunting of the right leg; the right patella tendon reflex was much increased; hearing was much reduced in the right ear; there was no choked disc or optic neuritis; none of the orbital muscles were involved. Speech was slow. A diagnosis of cerebral tumor originating in the leg centre of the cortical area of the left hemisphere of the brain and extending downward and forward to the arm and face centres, was made, and operation advised, after specific treatment was tried without avail.

The remaining paper in this issue is "Induration After Lobar Pneumonia," by Dr. Ludwig Hektoen.

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### Nervous Headache.

℞ Potass. Brom..... 4 drms
Liq. Tong. Sal..... 8 ozs

M. ft. sol. Sig.: Teaspoonful every hour until the desired effect is secured.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Oderless Iodoform.

Iodoform it is said can have its disreputable odor successfully masked in the following combination: Iodoform, powdered benzoin, powdered cinchona, and magnesium carbonate, equal parts and a little oil of eucalyptus. The formula is credited to Lucas-Championniere.

### Choloform in the Treatment of Tania.

The following has proved useful:

℞ Spts. cholorformi.....5j
Ol Crotonis (Tiglii).....gtts. j
Glycerini.....5j
M. For one dose.

—*Dr. Graesse.*

### Apomorphine for Hysteria.

Rossen reports success in cutting short hysterical attacks and in preventing their recurrence by the administration of one-tenth of a grain of apomorphine hypodermically. In the case of a morphine user, the impression was given that the apomorphine was the drug to which she was accustomed; and in consequence the morphine habit was permanently broken up.—*Times and Register.*

### Jaundice Due to Simple Obstruction Successfully Treated by Olive Oil.

Dr. Thos. Olive reports two cases in which symptoms, which had persisted for many months under vigorous medical treatment by himself and others, gradually disappeared under the administration of olive oil. He says: "In the treatment of recurrent hepatic colic I do not claim for olive oil that it dissolves the gallstones, nor do I regard the greenish concretions passed per anum by patients thus treated as softened gallstones. Microscopical and chemical examination have shown them to be practically nothing else than inspissated oil. Nevertheless as to its decided influence for good in certain cases of obstructive jaundice, I have no doubt. In such cases our experience at present is in advance of the therapeutical explanation."—*Lancet.*

### Reducing the Tonsils.

Dr. Tact De Blois believes that galvanocaustic puncture, while not a perfect method is the best we have at present at our command for reducing the size of enlarged tonsils. The operation is performed under cocaine anæsthesia. The cautery point is pushed about a quarter of an inch into the tonsil avoiding the crypts. The pain is not very severe. Slight inflammation follows and a little sloughing from the burned parts. Diminution of size, estimated at about a quarter, occasionally follows at the end of ten days after the first burning. The igni-puncture should be repeated perhaps three times. About half the cases will show some improvement after the first burning. In about quarter of the cases this treatment will prove so slow or so unsatisfactory that resort will have to be had to tonsilotomy.—*Bost. Med. and Surg. Journal.*

### The Action of Permanganate of Potassium in Rendering Morphia Inert.

At a meeting of the Medical and Surgical staff of the West side German Clinic, Forty-second street, New York, Dr. Wm. Moor, one of the physicians to the clinic, recently gave a demonstration on his own person of the efficacy of permanganate of potassium, as an antidote for morphia. Against the earnest protestations of those present, he swallowed 3 grains of sulphate of morphia in solution and immediately afterwards he drank a solution of four grain of permanganate of potassium in four ounces of water. He was carefully watched, but none of the ordinary effects of morphia on the system were observed, and he has since stated that he experienced no ill effect whatever from the poisonous dose taken. He claims that morphia or any of the salts of opium are immediately rendered harmless by contact with the permanganate. The antidote should be administered as promptly as possible after the morphia is taken. Experiments indicate that the permanganate does not control the action of the poison after it is introduced into the general system. Since the demonstration it has been claimed that the honor of discovery is really due to Dr. Wm. Condy, of London.—*Bost. Med. and Surg. Journ.*

### Post Mortem Idrosis.

A writer in the *International Medical Magazine*, records the following curious phenomenon in a case of death from angina pectoris. "The face of the corps seemed to be bathed in prespiration, the moisture reproducing itself after being wiped off, in spite of the presence of rigor mortis, and other unmistakable evidences of death. This most extraordinary phenomenon was witnessed by several local physicians, who also viewed the body. The funeral on that account was delayed several hours, until decomposition had fully set in."

### Burns.

℞ Cocaine hydrochlorate.....gr. v.
Campho-phenique.....
Olive-oil.....āā ℥ss
M. Rub up the cocaine and campho-phenique and add the olive-oil.

—*Medical Review.*

## SURGERY.

### Intubation of the Larynx in Private Practice—Results in 78 Cases.

C. M. Whitney, in *Bost. Med. and Surg. Journal*, divided according to age. They were:

| | Cases. | Recoveries. |
|---|---|---|
| Under 1 year | 2 | 0 |
| One—2 years | 12 | 3 |
| Two—3 years | 18 | 6 |
| Three—5 years | 20 | 5 |
| Five—10 years | 26 | 12 |
| | 78 | 26 |

This table shows 33 per cent. of recoveries. When there is persistent and increasing retraction of the intercostal, supusternal and super clavicular spaces, no advantage is to be gained by waiting, but intubation should be done at once. The writer mentions some changes he has made in the apparatus and gives careful direction about the details of introducing the tube. A list of the articles of food which may be administered during the wearing of the tube is given. From the fourth to the sixth day the tube should be removed. This is far more difficult than its introduction. An extractor divised by Dr. Nichols, of the Boston City Hospital, is favorably mentioned. Intubation is an operation especially adapted to private practice—always available, can be done early, and is painless and bloodless. It is not advisable when the tonsils are so large that they prevent the necessary manipulation or when the fauces are full of putrid debris and the epiglottis is immovable from the distructive action of the disease.

### The Treatment of Influenza.

Dr. Wm. Henry Thayer writing to the *Medical Record* of his treatment of influenza in the epidemics of 1891 and 1892 says: It was treated as we should treat diphtheria, with bichloride of mercury, adopted on the ground of its being a powerful germicide. I treated all my cases that way and with excellent results. In seven attacks it was given in doses of 1-30 gr. every half hour at the outset for several hours, and continued at longer intervals afterward. The effect was always good on the prime disease, and the convalescence usually so tedious, and in lessening the frequency of secondary affections.

### The Indications For Bleeding.

Sir. Benjamin Ward Richardson, is rather fond of bleeding, and in his *Aesclepiad* he has published several articles describing his experiences and his successes. In the last issue of this Journal he tries to indicate the moment for bleeding, and the conclusions to which he arrives, are these:

One may bleed—

*a.* In acute spasmodic seizures, as in spasms of croup, in colic and in augina with symptoms of oppression from distension of the right side of the heart with blood.

*b.* In acute pain, membranous or spasmodic, as in sudden pleuritic or peritoneal pain, or in pain from passage of a calculus hepatic or renal.

*c.* In acute congestions of vascular organs, as of the lungs or brain, apoplexies.

*d.* In cases of sudden shock or strain, as after a fall or a blow, sunstroke or a lightning shock.

*e.* In some exceptional cases of hemorrhage of an acute kind, unattended by pyrexia.

This, it seems to us makes a rather poor showing for venesection. It means practically, that bleeding is only needed in urœmic convulsions and dangerous apoplexy, for in most of the other conditions morphine, or some heart stimulant would answer as well, if not better.

The fact is, bleeding has gone forever from ordinary therapeutics. This is not because it is useless, but because modern science has devised better things as substitutes. Bleeding was legitimate and effective in its day, and would be useful now if our materia medic had not been so enlarged. We have given it up, not because of a change of fashion, but because we have outgrown it.—*Ed. Medical Reaord.*

## ARMY AND NAVY.

U. S. ARMY FROM FEBRUARY 18, 1894, TO FEBRUARY 24, 1894.

The leave of absence on Surgeon's certificate of disability granted Major Edward B. Moseley, Surgeon, U. S. Army, is extended one month on surgeon's certificate of disability.

First Lieutenant Benjamin L. Ten Eyck, Assistant Surgeon, U. S. Army, will report in person to Colonel Joseph C. Baily, Asst. Surg. General, president of the examination as to his fitness for promotion.

U. S. MARINE HOSPITAL SERVICE FOR THE FOUR WEEKS ENDED FEBRUARY 17, 1894.

Murray, R. D., Surgeon; to proceed to Key West, Fla., for special duty, January 26, 1894.

Bailhache, P. H., Surgeon; granted leave of absence for twenty days, February 2, 1894.

Purviance, George, Surgeon; detailed as Chairman Board of Examiners, February, 12, 1894.

Stoner, G. W., Surgeon; detailed as member Board of Examiners, February 12, 1894.

Carter, H. R., Surgeon; to report at Bureau for temporary duty, February 2, 1894; to proceed to Brunswick, Ga., as Quarantine Inspector, February 6, 1894; detailed as recorder Board of Examiners, February 12, 1894.

White, J. H., Passed Assistant Surgeon; granted leave of absence for seven days, February 17, 1894.

Carrington, P. M., Passed Assistant Surgeon; granted leave of absence for thirty days, February 19, 1894.

Bratton, W. D., Passed Assistant Surgeon; granted leave of absence for thirty days, January 20, 1894.

Pettus, W. J., Passed Assistant Surgeon; granted leave of absence for thirty days, January 30, 1894.

Vaughn, G. T., Passed Assistant Surgeon; to report to the Secretary of the Treasury for special duty, January 26, 1894.

Young, G. B., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Stimpson, W. G., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Brown, W. B., Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Rosenau, M. J., Assistant Surgeon; granted leave of absence for thirty days, February 26, 1894.

Cofer, L. E., Assistant Surgeon; to proceed to Mobile, Ala., for duty, January 30, 1894.

Eager, J. M., Assistant Surgeon; granted leave of absence for four days, January 30, 1894.

Blue Rupert, Assistant Surgeon; granted leave of absence for eight days, January 26, 1894.

Norman, Seaton, Assistant Surgeon; ordered to examination for promotion, February 14, 1894.

Prochazka, Emil, Assistant Surgeon; to proceed to New York, N. Y., for duty, January 24, 1894; to proceed to Buffalo, N. Y., for temporary duty, Eebruary 2, 1894.

## NEWS AND MISCELLANY.

### Medical Society of the State of Pennsylvania.

COMMITTEE ON SCIENTIFIC BUSINESS.

Dear Doctor:—At its last meeting the Medical Society of the State of Pennsylvania appointed—under the provisions of a by-law proposed at Harrisburg and adopted at Williamsport—a Committee on Scientific Business, "To secure scientific papers and to provide scientific discussions for each annual meeting, and to co-operate with the Committee of Arrangements and Credentials in arranging the programme." The members of this Committee are Drs. Dulles, of Philadelphia; Gorgas, of Harrisburg; LeMoyne, of Pittsburg; Tyson of Philadelphia; and Towler of Marienville. The object of this change in the law is to have a permanent Committee which, becoming familiar with the subject, shall find it easier to secure good scientific work than is possible for a committee that is appointed new every year.

The Committee on Scientific Business is working in conjunction with the Committee of Arrangements, of which Dr. E E. Montgomery is Chairman, and will co-operate with it in arranging the programme.

The committee hopes that each member of the State Society will aid it in attempting to make the meeting of the Society of greater scientific importance than they have been in the past. To this end the Committee will welcome suggestions from any member of the Society and especially, at this time, offers of contributions to the work of the next meeting, at Gettysburg, May 15 to 18. It is desired that there should be as many brief, concise, practical papers as possible, and it is proposed to have a discussion on Tuberculosis, devoting the morning to "Medical Tuberculosis," and the afternoon to "Surgical Tuberculosis"

Any communication from members of the Society in regard to the work of the Committee will be welcome by it.

Members of the Society desiring to read papers, or to take part in the discussion on Tuberculosis will please notify the Chairman of the Committee.

DR. CHARLES W. DULLES,
4101 Walnut Street, Philadelphia.

### To Those who Read Medical Society Papers.

We have often seen this notice over doors entering manufacturing places: *Keep out, this means you.* So we write this editorial for the members who took part in the last meeting and for those who will engage in the next, and we add this: *Read it, this means you.*

Time your article beforehand. Boil it down until it can be delivered in fifteen minutes. This rule would have seemed at least two hours for debate in the recent meeting.

Confine yourself to manuscript strictly—interpolations and after remarks are wasteful and exceedingly tiresome.

Be familiar with your piece, one of the best articles of the session lost not a little of its attractiveness because the author was unable to decipher his writing so as to read it in an easy manner.

Be brief, others are anxious to speak as well as you. Enthusiasm is a good thing but when a doctor talks an hour he wearies his audience and cheats his colleagues.

Be sure you have something to say when you talk, then say it concisely, clearly and but once.

In discussions don't repeat the author's paper agreeing in all points; briefly allude to them, and dwell only on something not yet mentioned.

If a doctor reports a very uniquecase, d on't dampen his ardor by always havi ng one just like it. If you habitually do so you will be regarded as an hereditary exaggerator—*South Cal. Practitioner.*

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### THE FORMATIVE PERIODS OF MEDICAL NOMENCLATURE.

A. L. BENEDICT, A.M., M. D.,* Buffalo, N. Y.

The present is a time when what may be called the medical dialect of the English language is rapidly growing. It is worth while to pause and consider whether those of the medical profession who are coining new words, and the rank and file who are accepting them and giving them currency, are doing justice to themselves and to succeeding generations among whom the present output of terms will continue to circulate. Let us admit at the outset that it is infinitely nobler to be able to recognize a disease and to treat it skillfully, than it is to be faultless in the choice of language with which to describe the various steps towards the desired end. Never-the-less, it must be remembered that medicine is a profession, not a trade, and that something more is demanded of the physician than the mechanically correct performance of a task. There is much excuse for the Bostonian, who in reply to the question: "What did the doctor pronounce your trouble?" said, "He pronounced it eczéma, and I discharged him immediately." The man who wishes the esteem of his associates must be more than utilitarian, and especially must be correct in details of language, whose use or misuse betrays his standing to every casual acquaintance.

In the infancy of any branch of science, there is an opportunity for the reasonably careful observer, even though he observes superficially, to discover an enormous mass of new facts, and there is a corresponding rapid increase in technical words and expressions. Then there is a period during which facts are correlated and assimilated, while the terminology is revised and improved but without much addition. Again there comes a time when, with more exhaustive methods of research and with concerted efforts to penetrate beneath the surface facts, a second demand is made for a new issue of verbal currency with which to expedite the interchange of newly acquired ideas. No other branch of science has demanded so great an increase of terms as has medicine, and the explanation is easy. In the first place, medicine is not an entity, but the bringing together of all parts of chemistry, botany, anatomy, physiology, microscopy and many other subjects that can have any bearing, practical or theoretical, on the healing art. In the second place, other useful arts and sciences content themselves with a terminology for general principles and a few descriptive structural terms. For example, the botanist uses names that will indicate the classification of a plant and the function and shape of its component parts, but his description fails to reproduce an image of the particular plant which he has in mind. On the other hand, in the matter of anatomy alone, the physician must have a terminology that shall express vividly and exactly the most complex relations of structures, compared with which the boundaries of states and countries, the course of

*Consultant in Digestive Diseases, Riverside Hospital.

rivers and railroads, the location of mountain ranges and other geographical land-marks are of the utmost simplicity. In other medical sciences, like necessity exists for concise and definite expressions. It is not surprising, then, that the average medical student spends at least a year in acquiring a fairly accurate knowledge of the meaning of words.

The first period of word-building for medical science was necessitated by anatomical research, the tendency toward the use of standard preparations of drugs and the recognition of typical groups of symptoms as marking certain diseases. The perspective of time enables us to disregard the long intervals which really separated the efforts of different investigators and to consider the results of several centuries, as simply a step towards the formation of a medical vocabulary. The nomenclature of this period is almost entirely Latin, and fortunately, the educated men were so familiar with that language that their terminology is almost beyond criticism from the grammatical standpoint. It is a curious fact that we have retained the original Latin forms in speaking of bones and muscles, while we have anglicised the names of vessels, nerves and most ligaments. For example, it is customary to say, "extensor communis digitorum," instead of "common extender of the fingers," but we say, "femoral artery," rather than "arteria femoralis."

The question has often been raised whether a nomenclature taken almost bodily from a foreign language is best adapted to the needs of the profession, but there are excellent reasons for upholding it. It is convenient to employ terms that are unintelligible to patients themselves. Most clinics would be positively brutal if the lecture were given in language that the patient could clearly understand. Note how the disease vulgarly called 'pox' has been in turn spoken of as syphilis, specific trouble and finally lues, in the attempt to keep ahead of the patient's knowledge of terms. Note also that consumption—itself a Latin euphemism has been translated into Greek as phthisis, pronounced successively teesis, tisis and thisis, that these words have been replaced by pulmonary tuberculosis, while since Koch's discoveries have become widely known, all sorts of circumlocution have been used to elude the increasing knowledge of the laity. Another reason for preferring that a scientific nomenclature should be drawn from foreign sources is that familiar words become encrusted with secondary meanings which connect them with other words and tend to conduct the thought away from the object to which it should be confined. The word fibula, for example, suggests to the anatomist the outer bone of the lower leg, and nothing else. Literally, it means a clasp, buckle, connecting pin or bond; but none of these English expressions would be sufficiently definite. The best reductio ad absurdum of the use of a home-made nomenclature is afforded by the Germans. By a curious anomaly, they use side by side a much purer medical Latin than we do, and such verbal monstrosities as heart-bottle for pericardium, slime-skin for mucous membrane and beat-vein for artery. Perhaps, it is because the educated Germans have almost a speaking familiarity with Latin that they are so much less pedantic in the use of it.

But the result is a practical disadvantage to English-speaking physicians, for, while the medical literature of other countries has a technical nomenclature almost identical with our own, that of Germany—the most valuable of all—presents great obstacles to the translator.

An objectionable feature of medical nomenclature, not alone of the first period, but of the present, has been alluded to in these words by Dr. Oliver Wendell Holmes: "If a doctor has the luck to find out a new malady, it is tied to his name, like a tin kettle to a dog's tail, and he goes clattering down the highway of fame to posterity with his æolo attachment following at his heels." It is a very doubtful honor to have one's name go down to future generations to be cursed by successive classes of students who are already overworked to remember necessary facts without being burdened with biographical association. The injustice is often done of immortalizing the name, not of the real discoverer, but of some one who has brought his discovery into prominence, or who has been accidentally connected with it. Moreover, the conspicuous anatomical land-marks, which have been made to serve as monuments to the memory of early dissectors, are such as anyone would notice. The fissures of Sylvius and of Rolando in the brain, can not be said to have been discovered, except in the sense that one

might discover that animals breathe or that the sun rises. No one thinks of naming part of the brain after Burt G. Wilder or W. W. Keen, although either has done more solid work in that part of anatomy than all the older anatomists combined.

The second period of growth in the vocabulary of medicine marks the renaissance of medical science. The systematic use of the microscope developed, almost created, the sciences of histology, embryology and pathology. Ingenious instruments and practical experimentation cleared up doubtful problems in physiology and established pharmacology — the exact knowledge of the action of drugs. Bacteriology opened new worlds of conquest and its practical expression, the use of antiseptic methods to prevent wound infection, made possible the surgery of the brain and abdominal cavity. Critical study revealed a host of new facts and new words were necessary to mark the paths of a multitude of pioneers in every field of medical science. In the preparation of a recent medical dictionary, there was assigned to one man simply the collection of words referring to the modern discoveries in the physiology of the liver, gall-bladder and their ducts and to the new operations on that part of the body. We are almost compelled to designate modern operative methods and clinical discoveries by proper names. It would take a sentence to locate McBurney's point, a paragraph to explain the Argyll-Robertson pupil, a chapter to describe Emmett's operation. Such a nomenclature is photographic in its convenience and accuracy. A less arbitrary and more technical description would be like a painted portrait, more artistic but too wasteful of time and less reliable as to details. Yet it must be hoped that this tendency to use personal names will be held in check and regarded as intrinsically evil.

The question between a foreign and a home-made terminology has been decided in favor of the former by the vote of almost every one who has had occasion to add a word to our already large vocabulary. A few imitators of German embryologists have familiarized us with *mid-gut* and *hind-brain*, but it is significant that most of the new words are of Greek origin and not even of Latin! Why do we say *bacteriology*, *micrococcus*, *pyo-phylactic gastrostomy*, *enteralgia*, *salpingitis* and *neuroma* instead of their Latin equivalents? The reason is not hard to find. English is only nominally a Germanic language; after the first few hundred words necessary in gaining food and shelter, the bulk of our dictionary is filled with words more or less directly taken from the Latin. The most ignorant would recognize nothing stilted or foreign in such words as *city*, *street*, *cause*, *fact*, *add*, *hour*, *school*, *real*, *solid*, *pen*, *table*, and yet all of these are but slightly changed Latin words. Unconsciously, the demand for foreignness, for separation from commonly used expressions, has been so urgent in the case of new scientific discoveries needing names, that not even Latin has been able to satisfy this demand and recourse has been had to Greek. If one could read the future, it would be interesting to know if the next great leaps of medical science will leave their imprint in derivatives from Hebrew or some other language.

History repeats itself. When the English language had assimilated the Latin words which came to it through the Norman conquest and the scholastic writers of the Elizabethan era, the unique phenomenon was presented of a double language having Saxon and Latin equivalents for a great many ideas. So in our present medical terminology we are compelled to have both a Latin and a Greek vocabulary. Thus we say *pulmonary* but *pneumonitis*, *intestinal* and *enteritis*, *cæcum* and *typhlitis*, *vesical* and *cystic*. In many instances English, Latin and Greek synonyms are all in common use, for example blister, vesicant, epispastic; sweat, sudorific, diaphoretic. The facility of the Greek language for forming compounds and supplying prefixes and suffixes has doubtless favored its use in science. Thus we have *ectoderm*, *mesoderm*, *entoderm*, referring to the outer, middle and inner membranes or skins from which the embryo develops; *epidermis*, meaning the covering upon the true skin; *hypodermatic*, describing an injection under the skin; *dermoid* (better *dermatoid*) referring to a tumor whose contents are skin-like; *dermatitis*, meaning an inflammation of the skin; *dermatoma*, a tumor of the skin; *dermatology*, the science of skin diseases; and many others. So an inflammation of any organ is denoted by the termination *-itis* preceded

by the name of the organ; the tumors end in *-oma*; the aches in *-algia*, the discharges in *r-rhœa*. These few illustrations will show how wonderfully plastic the Greek language is—unfortunately it is not always moulded by skillful hands. The standard of classical education has declined since the first period of growth of the medical vocabulary. Whereas the men who bestowed anatomical and pharmacal names could write and speak quite fluently a Latin which was correct in its inflections and syntax, if not in construction, there are at present too many advantages in scientific and practical education to leave much time for the classics. The speaking of either Latin or Greek is an almost unheard of accomplishment, and few of the most erudite, unless actively engaged in teaching these languages, can do more than stumble through a translation of the simplest classical writings. The law of the state of New York, which has been enforced only against those who began the study of medicine after June 13, 1893, requires for admission to a medical college simply a common-school education. One would naturally think that the only objection to the law would be that by making such a requirement, it would be construed as formally approving of the minimum education. On the contary, it was bitterly opposed, not only by some of the prospective students but by many practicing physicians and a few medical colleges, on the ground that it required too much. It was carried only by long continued, hard work on the part of its advocates, the better class of physicians, and was subsequently threatened by amendments which would have delayed its operation and crippled its effectiveness. Yet New York, whose law requires little more than a self-respecting ditch digger would consider necessary, is surpassed by few states in the matter of preliminary medical education, and, astonishing as it may seem, a perceptible improvement has followed the enactment of this law. It must not be supposed, however, that the progress of medical science or the standing of reputable physicians and surgeons can be judged by the educational minimum legalized in this state, or, by the greater depths of ignorance permitted in others. Almost without exception, the men of prominence in the profession or those who come in contact with the intelligent part of the community, are well prepared for the work in which they are engaged. They set the pace for medical and surgical progress, while those who would be affected by any possible legal requirements follow as well as they can and are not missed if they drop behind.

Yet the fact remains that the medical profession has not always acquitted itself creditably in following the precedent of deriving its new words from the Greek. In a recent paper on "The Spelling of Some Medical words," Dr. George M. Gould, in the *Medical News* says: "When a word is desired, the modern writer snaps out his Liddell and Scott, gets some words that best suit his purpose and shakes them together in his etymologic basket until they cohere into some sort of unity, not infrequently a very ludicrous one." This sentence pithily expresses the fact that, while the rank and file of the medical profession are unable to do more than memorize arbitrarily the terminology provided for them, the men who create and supply the demand for fresh words, depend for the most part on the half-remembered remnants of an early training. Mistakes are inevitable. For example the word laparotomy, which is almost universally understood as involving an opening into the peritoneal cavity through the middle line, means a cutting into the flanks. Exception has been taken to the word symphysiotomy, which applies to the separation of the innominate bones at the pubes so as to allow a springing apart of the pelvis. The word symphysis means a growing together and should not be used in a new compound in the limited sense of the union of the pubic bones. Yet the alternative suggested, pubeotomy illustrates one of the most glaring sins against literary decency, for it involves the miscegenation of a Latin and a Greek word. The word ovariotomy is another mongrel of this description. It should be replaced by the word oöphorectomy (egg-bearer outcutting) but is retained on account of the arbitrary distinction between an operation for the removal of a large ovarian tumor, and one for the removal of normal and slightly-enlarged ovaries. Tonsillitis and uvulitis are similar misunions of Latin and Greek elements, and should be replaced by amygdalitis and staphylitis for the Greeks used amygdale, whose literal meaning is

almond, for tonsil, and staphyle—a bunch of grapes—for uvula. Perhaps the most flagrant illustration of this kind is endo-cervicitis, whose perpetrator must have had an endo-head-itis. Endo-trachelitis, meaning literally inflammation of the inside of the neck, is at least all Greek, but is objectionable in using the general word for neck in a special sense. Cervical endo-metritis would be preferable to either and not much longer. Many similiar errors might be mentioned. Some of the worst illustrations of the tendency to say in one long word what might better be expressed in a few short ones, are found in the description of gastric neuroses, hyperacid, an-acid, hypo-acid, etc., and in the word uricacidæmia, which is only one step removed from grape-sugar-æmia.

In spite of the errors alluded to in this paper, there is good reason for congratulation that the rapid growth of medical terminology has been on the whole, healthy and symmetrical. To guard against the perpetuation of faulty word-forms, the writer would suggest that some of the International, or even American medical congresses appoint a committee to examine the credentials of new terms, and to report upon words to be discarded or modified. The same end could be reached as well, though less formally, by concerted action on the part of editors of medical journals. No other class of physicians is so widely and recently informed, and no other has the same advantage of a position from which instruction of their colleagues is so readily given and so freely accepted. An editorial committee could recommend changes as wisely as any having the authority of a powerful medical association, and lists of words to be adopted or expunged, could, through the columns of the journals, be given wide circulation. Moreover, teaching by example as well as by precept, would be possible in all parts of the journals that are under editorial control.

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## DISPUTED POINTS IN PELVIC PATHOLOGY AND SURGERY.

JOSEPH PRICE, A. M., M. D., PHILADELPHIA.

In the medical profession very many of the old school are unwilling to accept the attested scientific facts of the new school. They are usually men so saturated with old ideas and beliefs that to them every new ideal, every revelation of a new truth in medicine or surgery is a medical or surgical heresy. And then we have the irreverent, iconoclast, the sacred bull amid sacred china, the man whose position is gained and kept for a little while more through the sweat of his jaws than the sweat of his brain. He is not a votary of either the old or the new school, he is a seat of learning all to himself—all his facts are his own—he has no interest in, and nothing to do with other people's facts. These nondescripts are usually mere bundles of little aggravations.

A few years ago intra-uterine applications and tinkering were practically abandoned by a large number of prominent gynecologists, by the men who recognized that gynecology had not reached the dignity of an exact science, that they were yet in their primers as to many needed lessons, to whom the diseases of women were a profound study—not simply a diversion, idle novel reading.

Many of the old methods of procedure were found useless and often dangerous; they were but the out-growth and crude expedients of emergency to be condemned by more enlightened experience. Most authors in discussing disease, treatment and procedure have a few accidents and not a few deaths to cite.

There still are those in the young school claiming to revise procedures without a careful study of their earlier history, who lose sight of the fact that these procedures had been very studiously tested by men much more thoroughly experienced and competent than they, without too much tension upon their modesty, could claim to be.

For awhile the enthusiast, the fresh graduate, critic and reviewer, the new-

fledged, fresh-blossoming gynecological recruit, with few or no experiences, heralds and claims everything for his particular application, method of dilatation, irrigation and drainage. Later he ventures to predict that the uterus will be removed in all cases, an organ that has little to do with the patient's condition in very many instances. Again, early in his trial trips, he washes the septic uterus once an hour, examines all puerperal cases about the tenth day, and makes an application to unhealthy cervix and to the cavity of the uterus.

A few men practically interested in both practical obstetrics and gynecology find such tinkering dangerous. The exceptions commonly seized by disputants are retained placenta or neglected abortions. Nearly all active practitioners have such cases to treat. They are to them not something guessed at, but characteristic symptoms to be promptly dealt with. The general practitioner as well as the specialist fully realizes the importance of emptying the uterus of debris, of all decomposing particles. There is an apportunity in these cases for grave error in diagnosis and treatment.

The absence of one or more periods, pain and prolonged hemorrhage, the passage of clot, shreds of debris or decidua, is not always an abortion, but often an extra-uterine pregnancy, or may be occasionally due to suppuration of tubes and ovaries. I have repeatedly removed a ruptured tubal pregnancy a few days after the curette had been used very freely by a physician mistaken as to the real character of his case.

Men who now deny the mortality following the 'let alone' or palliative treatment of tubal and ovarian disease, a few years ago, while interested in pelvic surgery, made repeated reference to the chronic invalidism, long suffering and numerous deaths in these cases and urged upon the profession through elaborate papers the very frequent occurrence of neuroses, numerous sinuses above and below, and the tedious convalescence, if they recovered at all, and also the impossibility to relieve, cure or save life without resort to surgery. There was a large number of these cases then as now. Now some of these same authors contradict their own teaching. Now they claim that they can be relieved and cured and conception follow, this notwithstanding they know or should know that extensive disorganization has long since destroyed all possibility of conception.

Incisions, tents and other methods of treatment have resulted in a large number of cases of peritonitis and abscess. A small group of cases are recorded as dying of tetanus as a result of the use of the tent.

I have been asked to see patients by men bitterly opposed to operative interference. In spite of their well-directed treatment the patient grew worse, their condition the more alarming. Some I found dying, others very ill. Some are saved by prompt interference, others die before the family or friends have time to consider the matter fully. The physician or physicians make post-mortems in some cases and bring me the specimens, telling me that the operation would have been impossible, that the complications were too great, that the post-mortem was only possible with knife and scissors. This has occurred repeatedly in this city and about it, also in neighboring states. We now save large numbers of women who would die of general infection in a few months under so called conservative treatment, or the application of those delusive devices, which deceive patients and friends by affording only temporary relief.

They are saved by prompt, painstaking and skillful surgery. Delays are wholly responsible for infection, emaciation, renal disease, coughs, phthisis and extensive bowel complications, all of which troubles increase our mortality or augment the risk and complicate the surgery in a number of those cases that change hands and submit to operative interference at the eleventh hour.

The importance of pathological knowledge is vital, for without it it will always be difficult for a surgeon to decide when to act, and when not to act. Again, thorough practical knowledge of diagnosis is essential to determine what line of treatment promises the best results. Without such knowledge or skill there is always danger of a surgeon doing mischief. When he combines ignorance, want of skill, or both, with a fondness for surgery, he is a dangerous man in any community. Take any old salt or tar and he will know and do better. He would intuitively recognize the extent of his knowledge, the limit of his powers, and would keep hands

off and not incur fearful responsibility or invite calamity. These neophytes in surgery illustrate the proverb—"Fools rush in where angels fear to tread!'

While operators continue to give so much prominence to simple pain and tenderness, chill and fever, they will continue to make errors.

It is important to locate the uterus, to determine accurately its relation to accumulations in the pelvis, fixed or movable, lateral or posterior, size, fixation and consistence, and the physical characteristics of lateral masses.

Simple tenderness and pain is misleading.

An occluded tube with retention of blood, pus or water is about always fixed by simple or extensive adhesions. The history of such cases, with the common objective signs, are important and are of great assistance in forming an accurate surgical judgment of what we have to deal with and how to deal with it.

I make the statement without fear of its being successfully controverted, that diseased, disorganized and occluded tubes, with retention, never return to health or perform their physiological functions. The numerous references to case, of diseased or occluded tubes being followed by conception is simply an error in pathology and diagnosis.

I have repeatedly removed a diseased or occluded tube of one side, recognized before operation, and have stated to the patient that probably the removal of the offending side would favor conception—which followed in a number of cases.

I insist upon examinations without the use of an anæsthetic. The coöperation of the patient, is important and sufficient.

In dispensary work the student soon becomes familiar with tubal and ovarian diseases without the use of anæsthetics. He tells quickly what he finds, and on which side the trouble is most marked, and this without complaint of pain on the part of the patient.

Unfortunately, too many operators in the past have been influenced by history, neuroses, hysteria, sterility, back-ache, dysmenorrhœa—by symptoms rather than by objective signs. This is an error, and is the source largely of the disrepute of much of this work, and the confusion that should not prevail. With accurate knowledge of pathology and diagnosis, there will be less wrangling over and less mistakes in our surgery.

We all realize the importance of a more uniform consensus of opinion, and the importance of this society maintaining the principles of sound pathology and surgery. Our medical societies are in a sense operating rooms where object lessons are given. They are the educating and re-educating institutions of our profession. The refinements of surgery and obstetrics are obtained by the concentration, the consecration of time, labor, thought and energy to practical work—by eschewing conservative methods, tapping, incising, fancied ingenious methods, novel contrivences, parade of tables, strained or unnatural positions, terraced sutures and much of our bacteriological lore.

We have done a great work as a society, both in obstetrics and surgical gynecology, a work of great value to science and suffering women. As ardent votaries of a science we have not been groping our way in a spirit of blind faith, we accept only that, the verity of which is confirmed by experience and stands the tests of appeal to experiment and observation. We have grappled with complex problems many of which have not yet been settled to our satisfaction. We may yet be dealing with but elementary truths, but we would deal with them so conscientiously, so studiously as to get down to the deeper underlying truths. We meet in our societies to get at facts, the best logic of our science.

All our triumphs over disease must come of our improved knowledge, our advanced skill in our work. If we have increased the average of human life, it is because we know more and better and promote more strictly and scientifically the conditions of health, than did our forefathers. And if our success in dealing with diseased conditions is greater than theirs, it is because we have used wisely the many lessons they left us as rich legacy, and with vigor and spirit have added to the knowledge they have transmitted. Better know more of nature and the better obey her laws and provide against pestilence in its varied forms. Through our better facilities we have a more accurate and broader knowledge of the laws of hygiene, know more of chemistry, of human anatomy, of physics; know more in every department of medical science. Yet splendid as may

have been and are our facilities, marvelous as has been our advances along all lines, many and arduous will be the steps before the capstone is laid.

Under the compendious title of medicine there is included so very much, that we may well stand appalled at what is before us. We look upon our society as a potential agency, an inestimable aid to our efforts in the immense work. In medicine there are no serene retreats—all its paths are rugged and thick strewn with inviting mysteries; with problems deep as life itself, and as old, which through all our advances we have been solving only in fragments.

Our society has done more than stimulate our efforts, it has awakened higher conceptions of our duties and possibilities; we have gone out from it with the strength, even of our clashes in which it has given us.

## COMMUNICATIONS.

### UNILATERAL PLEURISY WITH EFFUSION.*

J. M. ANDERS, M. D., PH. D.†

I have to-day two cases to show, one being a typical and the other an artificial case of pleurisy with effusion. The clinical history of the first is as follows:

M. C., male, aged thirty-seven years; birth-place, Italy; social state, single; family history, father and mother dead; causes of death not known. He has one sister living and well. No history of hereditary disease in the family.

Previous history: When a child he had measles, and later on an attack of chills and fever, but since that time has been in good health until the onset of the present disease. Two years ago he came to this country, but was unaffected by change of climate, and was always healthy up to the present time.

History of present disease: On December 23, 1893, the patient was seized with a sever rigor, followed by headache, intense lumbar and general muscular pains, which continued during the following week. Although unwell and unable to work at this time, he remained out of bed. One week later, December 31st, a sharp pain was experienced in the region of the right nipple, shooting backward to the scapula. On admission, January 3, 1894, the pain in the chest was less severe, accompanied by a dry, hacking cough, with slight expectoration. Respirations were somewhat increased and jerky in character, and some dyspnœa was noticeable, with cyanosis of the lips, eye-lids and finger tips.

Physical examination revealed the following: On inspection, the right side showed fullness with slight bulging of the intercostal spaces, expansion being perceptibly diminished on that side.

On palpating, tactile fremitis was absent over the lower two-thirds of the right lung, being somewhat exaggerated above this. Percussion, with the patient in the erect posture, showed absolute flatness below a line extending from the right nipple in front to the angle of the scapula posteriorly.

On ausculting, the breath sounds were found to be entirely absent over the affected area, and this in conjunction with the other physical signs established the diagnosis of pleural effusion.

To-day, as the patient lies before us, we will begin a systematic examination, by inspection, palpation, percussion and auscultation in regular order. The chest is a well-developed one, the muscles being well-defined. The two sides are symmetrical, with perhaps the slightest degree of bulging to the right. The respirations are still somewhat hurried and jerky in character. The movement on the right side is upward and downward rather than upwards and outwards, as occurs during normal respiration. The apex-beat is plainly visible, being displaced to the left, the pulsation extending to the anterior axilary line. There is no enlargement in the area of cardiac dullness, but displacement to the left has occurred. Several theories are advanced as to the cause of this displacement. It was thought formerly to be due to fluid pressing against the heart, but this has been disproven by the fact that it may, and often does occur with the *beginning* of the peural effusion. Among many explanations is one given by

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Garland, of Boston, which is as follows: The heart lies between the lungs, suspended from the third dorsal vertebra. The lungs being expansive retract on the two sides; that on the side of the pleural effusions has its elasticity impaired, hence its traction force is diminished. The healthy lung being unimpaired retracts and draws the heart to that side. The displacement being further increased by the effusion.

Later on intra-thoracic pressure becomes evident; the elasticity of the lung is destroyed and direct mechanical pressure results. After absorption of the exudate, displacement may be caused by pleuro-pericardial adhesions. Diminished expansion occurs, producing a vacuum and causing a sinking-in on that side of the chest. The intra-thoracic pressure on the affected side is lessened and this, together with the normal atmospheric pressure against the chest wall and the normal intra-thoracic pressure on the sound side, are factors which aid in the displacement. The spleen and liver are often slightly out of their normal position and displaced in a downward direction as detected by palpitation. During health the retractibility of the lungs exerts a traction force on the diaphragm below; this force is destroyed by an effusion filling two-thirds of the chest, or causing considerable intra-thoracic pressure the diaphragm becomes depressed, thus displacing downward the liver on the right side and the spleen on the left. Such cases should be watched with great care.

We will now have the patient sit up. On palpating over an effusion the entire hand should not be used as the boundary line between liquid and lung tissue cannot well be distinguished. Use the tips of the fingers, begin above and proceed downward. In this case I find posteriorly tactile fremitis unimpaired downward to one inch below the angle of the scapula, below that being entirely absent. This is not an absolute sign of effusion, as the entire chest may be filled with fluid and yet some fremitis be present, owing to fibrous bands in cases of chronic pleurisy transmitting vibrations from the lungs to the chest walls. On pressing the finger-tips in the right axilla between the ribs, and the latter tend to converge and do not expand as normally, the respiratory movement is also felt in an upward and downward direction. Percussing anteriorly shows flatness beginning on a level with the nipple and extending downward, with the patient in the sitting position. Percussion over a liquid should always be performed lightly and delicately, the sense of resistance imparted to the fingers often being felt distinctly. Above the nipple line a semi-tympanitic note is produced, showing exaggerated percussion resonance, above the effusion. Skoda's resonance which is a higher pitched note, is only heard when the effusion reaches up to the level of the fourth rib or higher. It also may occur under other conditions. Posteriorly percussion gives below the angle of the scapula a flat note, *i. e.*, one entirely without resonance. In pneumonic consolidation dullness may be obtained, but not absolute flatness, because the alveoli, although filled with exudate may transmit vibrations to the bronchial tubes. Complete dullness is not the same as flatness. In pleurisy with effusion we have absolute flatness; in pneumonia dullness alone may be present. From one to one and a half inches above the level of the effusion in this case, percussion gives a dull note because the lower border of the lung contains less air than normally. This may be caused by congestion or in some instances by œdema of that portion of the lung. Higher up we have exaggerated resonance, the note being elevated in pitch and vesiculo-tympanitic in character. The line of flatness in pleural effusions is not level when the patient sits erect, but gradually rises from the spine toward the axilla, being highest just behind the mid-axillary space, then falls as I proceed toward the sternum. This is an important sign in pleurisy. In a beginning effusion the liquid first comes in contact with the diaphragm, but this cannot be detected by physical examination, flatness on percession being first noticed in the axilla. Some authorities state that the upper line of flatness takes the form of the letter S, but more commonly a curved line which presents its convexity toward the head, is apparent, dullness changing with the position of the patient. In some instances the fluid presses on the diaphragm below and is confined between that muscle and the base of the lung, being prevented from changing its position by the elasticity of the latter. In hydro-pneumo-thorax the liquid moves much more readily because

the elastic force of the lung is lost. In diagnosing a pleural effusion, percussion signs are of the greatest importance, especially dullness changing with the position of the patient, which is apparent in this case. On having the patient lie down we find that resonance extends two inches below the nipple-line. On ausculting we have entire absence of respiratory and vocal sounds below the angle of the scapula, and on deep inspiration and speaking, sounds are transmitted feebly to the ear, although the respiratory murmur is totally absent. No friction rales are apparent because the fluid lies between and separates the pleural surfaces, although absence of pleuritic rales may be accounted for in other ways. The respiratory muscles from pressure may become completely paralyzed and total loss of motion result, as soon as the pressure is removed the muscle reacts and friction sounds may reappear. In the case before us the physical signs and clinical history all indicate pleurisy with effusion.

The subjective phenomena, such as pain in the side shooting to the back, embarrassed jerky respirations, dry croupy cough with scanty expectoration, and moderate amount of fever are not diagnostic. Displacement of the apex beat to the left, with total absence of vocal fremitis, flatness on percussion changing with the position of the patient, are of far more importance and render the diagnosis absolutely certain. But we do not have to deal always with a typical case. Pneumonia or tubercular consolidation may occur as complications. In the latter, evidences of disease are first detected at the apex or apices and progress downward. In the latter also one side is rarely effected throughout, as in the case of pleural effusion. Clinical history also aids in the differential diagnosis: In tubercular infiltration the progressive emaciation, hectic temperature, chronic cough with expectoration of purulent matter, which, when stained and examined microscopically is found to contain tubercle bacilli, all tend to establish the diagnosis without doubt. In croupous pneumonia the elasticity of the lung is overcome, compression of the alveolar structure results and we have dullness, *not* changing with the position of the patient, together with bronchial or tubular breathing and, if in the first stage of consolidation, the characteristic crepitant râle may be heard occuring at the end of inspiration. The attack begins often with a severe chill followed by high fever, extreme dyspnœa, panting respiration, cough with the expectoration of rusty sputa and on the sixth or seventh day crisis occurs, temperature drops to normal, profuse muco-purulent expectoration takes place and the patient enters convalescence. In this disease the physical signs show by inspection limited motion over the affected area, but *no* bulging of the intercostal spaces and *no* displacement of the heart or other viscera. Palpation gives *increased* tactile fremitis and percussion shows dullness, not flatness, which does not change with the patient's position. On ausculting in croupous pneumonia we have bronchial or tubular breathing all over the affected side, together with *increased* vocal resonance and broncophony, which extends to the base of the lung. This never occurs in a pleural effusion because there is a layer of fluid between the lung and diaphragm. In an effusion only when the chest is two-thirds filled with liquid may we get indistinct bronchial breathing over small areas just below the level of the fluid, together with impaired tactile fremitis and diminished vocal resonance. This has been proven by aspiration. Enlarged liver may be mistaken also for right-sided pleurisy, but in this there is no change of flatness varying with the position of the patient and no upper curved line as in a pleural effusion, together with absence of flatness in the mid-axillary region. Again the flatness due to an enlarged liver extends higher in front than posteriorly, which is the opposite in cases of pleurisy. A large abscess on the upper surface of the liver may give an arched line of flatness which, however, does not involve the whole side. In establishing the diagnosis of pleural effusion physical signs are of far more importance than the subjective phenomena.

Now, as regards the etiological factors in a case of pleurisy, in this instance the rigor, headache and severe muscular pains began one week before the development of stitch-like pain in the chest and other symptoms, thus indicating in all probability that the attack was preceded by one of influenza. Another case recently came under my notice, in which the diagnosis of influ-

enza was undoubted, being followed several days later by an attack of pleurisy with subsequent effusion. In this patient there is a history of exposure, but simple exposure does not always precipitate an attack. Very often predisposing causes are present; it is apt to be secondary to chronic alcoholism, chronic Bright's disease, although in this case the urine has been examined repeatedly and found to be normal. Acute infectious diseases also act as predisposing factors in the causation of pleurisy.

*Concerning the Prognosis:* In simple uncomplicated pleurisy when the general health is good, the prognosis as to life is always favorable. There may be, however, a rapid increase in the effusion, the heart's action or the respiratory functions may become suddenly embarrassed and death result. Relatives or friends of the patient should always be informed as to the liability of this occurrence. In some instances death has occurred suddenly and without apparent cause being demonstrated by post-mortem examinations. Finally, the serum may be converted into pus and an empyema result, thus preventing or retarding absorption, and further complicating the case. In recovery, the membranes are thickened, new tissue is formed and conditions are favorable for the development and growth of the bacillus of tuberculosis. Indeed, often the process is tubercular from the beginning and effusion results secondarily, as in the cases of so-called "tubercular pleurisy," which are very common, or, the process may begin as a simple inflammation and sero-fibrinous pleurisy result.

*Treatment of Pleurisy:* Simple or sero-fibrinous pleurisy is an inflammation, and not a transudation as occurs in hydro-thorax due to valvular heart or kidney disease, therefore, the first indication is to reduce the inflammation in the pleura, and thus limit the amount of exudation; not to get rid of the liquid. How is this to be accomplished? By local and general measures. If the blood pressure be good, give remedies that reduce the arterial tension as tr. veratrum viride, together with mild diaphoretic and diuretic mixtures. The patient before us is taking a mixture composed of citrate of potash, sweet spirits of nitre and solution of the acetate of ammonia, with additionally bashanis mixture. For the pain, opium is very efficient given in the form of sulphate of morphia hypodermically or in suppositories of the powdered drug or extract. It supports the heart and controls inflammations of serous membranes. Quinine should be given liberally, sixteen or twenty grains daily in divided doses. It also controls inflammation. Locally, mild counter irritation should be resorted to and continued through the fever. Weak sinapisms followed by poultices and protection by means of a cotton-jacket to the chest. When the febrile stage has subsided and the temperature becomes normal, promote absorption by means of moderate purgation together with the administration of iodide of potassium, and some form of iron, preferably the syrup of the iodide of iron. Diuretics and diaphoretics have not in my experience proved very efficient in hastening absorption of the exudate. Five (5) grains of potassium iodide with ten (10) minims of the syrup of the iodide of iron given four (4) times daily may be doubled or trebled varying with the circumstances attending the case. Another preparation much used in this connection is the syrup of the iodide of iron and manganese. But absorption will not always occur under medical treatment and tapping must be resorted to. In aspirating there are certain rules which must be borne in mind by the beginning as well as the older practitioner, both during the febrile stage and subsequently. Only when urgent symptoms are manifested and in cases of the gravest character should aspiration be performed during the febrile stage. When one pleural sac is entirely filled, which can be demonstrated by entire absence of Skoda's resonance and flatness reaching up to the clavicle, aspiration *must* be resorted to. If, during the course of a unilateral pleurisy with effusion, any complications should develop on the unaffected side, in the heart or lung, as demonstrated in the latter by the presence of moist rales, œgophony and impaired resonance, thus indicating œdema; or if the apex beat is displaced to the left and a murmur becomes apparent together with downward displacement of the liver and spleen and development of orthopnœa, aspirate immediately.

In double pleurisies also aspiration should be performed early. How long a

time should elapse after the temperature and active inflammation have subsided before determining to aspirate? If, on making a careful physical examination one week later no evidences of absorption can be obtained, aspirate; on the other hand, if the slighest degree of absorption has occurred at the end of that time, it will often continue uninterruptedly and disappear entirely without interferance. In subacute or chronic cases with effusion, absorption often does not begin until the fourth or fifth week or may not take place at all. In all such cases a good rule is to wait three weeks for the exudate to disappear and at the end of that time, if absorption has not begun, aspirate and remove a small quantity of fluid. This will often be followed by a rapid disappearance of the remainder. The patient before us has had some fever but no complications and as the fluid does not fill two-thirds of the pleural cavity at present there are no indications for aspirating. If after one week, absorption has not begun, some of the fluid will be withdrawn.

NOTE. One week later the internal treatment having been continued, the temperature had dropped to normal, the exudate had begun to disappear and the patients physical condition was much improved, in every respect, rendering aspiration unnecessary.

## OIL OF PEPPERMINT IN PULMONARY CONSUMPTION.

CHARLES B. WILLIAMS, A. B., M. D.,* PHILADELPHIA.

Dr. Carasso has recently published (*Deutsche Medicinische Wochenschrift*, No. 49, 1893) a new method of treating pulmonary consumption by means of the continuous inhalation of the oil of peppermint, with the internal administration of the same drug in combination with creasote and chloroform.

Dr. Carasso claims remarkable results in his treatment of cases of phthisis with the oil of peppermint: Not only were cases cured in the first stages of the malady, but even the more advanced stages, where cavities had already formed, were cured. Dr. Carasso states that if there is fever associated with this condition, it will disappear in a few days under this treatment. He ends by citing no less than thirty-nine cases of phthisis pulmonalis in which these remarkable results were obtained.

It has been already demonstrated by Braddon that the oil of peppermint has a bactericidal action, and further, it is a well established fact that chloroform possesses in a marked degree the same properties as an antiseptic. The writer was induced to give the above treatment a trial in a case of phthisis that was well advanced and had resisted almost every form of modern treatment. The patient had been given creasote in increasing doses in combination with cod liver oil, tonics, etc., without any appreciable change in his condition.

For the administration of the oil of peppermint the two following formulæ were prescribed.

℞ Creasoti.....mxcvi.
Chloroform.....mxxx
Olei menthæ pip.....mxcvj.
Spiritus vini rect .....q. s. ad. f℥vj.
M. Et fiat mistura.
SIG. Capiat drachmam unam ter in die, ex pauxillo lactis.

and as an inhalant

℞ Creasoti.....f℥i
Olei menthæ pip.....f℥ij
Tr. conii.....f℥ij.
Alcohol .....q. s ad. f℥i.
M. SIG. Inhalet gtt x. quarta quaquehora.

Carbolic acid in a somewhat smaller dose or thymol may be substituted for the creasote in this last formula.

In less than one week's time the patient returned and reported remarkable progress in his case since taking the above formulæ. His cough had almost ceased; the expectoration was diminished to a marked degree; a sharp pleuritic pain that had troubled him in his right side for some time past, had entirely disappeared. And there was a return of appetite, so that now the patient ate his meals with a relish that he had not experienced for many months. And finally he was able to resume his occupation as a carpenter at which he had not worked steadily for eight or nine weeks.

The dose of the oil of peppermint mixture has been increased from one tea-

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spoonful 3 times daily, to a teaspoonful every four hours, or four times daily. The patient is rapidly improving under the above treatment.

At the present era in medicine the advocates for new methods of treatment in disease are legion, but their claims for success in nine cases out of ten must be looked upon with suspicion and taken *cum grano salis.* A new drug or a new method of treatment can take rank with the old and classic remedies only when it has been found by repeated experiment and trial to cure or, at least ameliorate, the pathological conditions of the human body for which it has been employed.

Dr. Carasso has claimed great things for the oil of peppermint in phthisis pulmonalis; he cites thirty-nine cases of consumption in all its stages, every one of which have been more or less benefited by this simple drug. And, when we come to think, it has been by the use of simple drugs that the physicians of the good old times attained success in the treatment of their cases, for they used remedies that had been tried for centuries and had been proven by experience and practice to relieve certain pathological conditions. The writer thinks that at least this simple drug should be given a fair trial in order to ascertain fully whether it will effectually combat the invasions of that dread disease, consumption.

## PISTOL-BALL WOUND OF THE BRAIN DIVIDING THE LEFT OPTIC NERVE IN THE OPTIC FORAMEN; MENINGITIS; AUTOPSY.*

THOMAS G. MORTON, M. D.

John B., aged twenty-nine years, was brought to the Pennsylvaina Hospital about seven o'clock in the evening of January 5, 1894. Shortly before admission he received a pistol wound of the face; the ball completely divided the right lower eyelid, penetrated the upper maxillary bone, and passed apparently backward and to the left, when its further course could not be determined. The patient was semi-unconscious, but could be roused; he did not seem markedly shocked, but since he had been dringing heavily the symptoms were masked. Temperature was barely 98°, pulse 66, and respiration 24. He gave his name and address, but appeared unable to make further replies. There was moderate hemorrhage from mouth and nose. Breathing had been heavy, but became easier an hour or so after being placed in bed.

On admission the pupil of right eye was found moderately contrcted, but sensitive to light stimulus; the pupil of the left eye was contracted, but was immovably and widely dilated two hours later; an effort was made to determine the location of the ball by an incision below the eye. Examination of the wound by the introduction of the finger led to the conclusion that the orbit was not involved, but that the ball had passed across through the nasal cavity to the left and had entered the brain, and in its course had injured, if it had not destroyed, the optic nerve.

The following day the patient was taken before the class; he was then rational, complained of no pain, and replied to every inquiry. The movements of both eyes were normal; vision was apparently not disturbed in right eye, large and small objects being distinctly seen; left eye totally blind, pupil widely dilated, yet sensitive when light was thrown upon the right.

*January* 8. General condition less favorable; difficult to arouse; slightly delirious at night; temperature 103°; pupils constantly varying; right more contracted.

10th. Somewhat violent at times; temperature 102½°; requires to be confined in bed.

11th. Able to reply to questions, sat up in bed. The following examination was made by Dr. Thomas H. Fenton:

"*Right eye.* Pupil about 6.5 mm., somewhat oval horizontally, feebly sensitive to light stimulus.

"Optic disk fair size, somewhat oval vertically, rather dull in color, well out-

*Read before Phila. Acad. of Surgery, Feb. 5, 1894.

lined, margins slightly elevated; fundus rather deep in color; veins very full; arteries somewhat contracted; media clear, so that all details are possible, but general definition defective owing to the slight haziness of cornea; tension normal.

"*Left eye.* Pupil 4mm., not absolutely immobile but not responsive to light stimulus, either with right eye open or closed; somewhat sensitive when right is covered. Optic disk fair size and shape; definition very good; the temporal half is leaden white, devoid of vessels; all vessels contracted on the nasal side of disk and throughout fundus, which has distinctly anæmic appearance; arteries very much contracted; no structural change except just below disk margin, where there is a small horizontal hemorahage 1mm. in size; media perfectly clear; tension normal; eyes in good position; movements normal. Large ecchymosis, bulbar conjunctiva temporal side, observed today."

16th. Patient has rapidly failed, delirium has continued since last report, and he died at 11.10 with a temperature of nearly 104°.

*Post-mortem.*—The ball entered the superior maxillary bone just below the orbital rim, about one-eighth of an inch to the inner side of the infra-orbital foramen, passing upward, backward, and to the left through the nasal cavity, fracturing the ethmoid and vomer; the orbital plate of the frontal bone was fissured, destruction of left olfactory, breaking through the body of the sphenoid, tearing away the lesser wing on the left side, completely severing the left optic nerve in its groove or foramen; the ball then passed into the left frontal lobe, where it was found just inside a large wound which continued upward and slightly backward and penetrated nearly to the upper surface of the brain.

The brain tissue in and around this wound was softened and degenerated. Several fragments of bone were carried in the brain substance by the ball, which was flattened and very rough. Evidence of suppurative meningitis existed over the entire base of the brain, and the vessels of the pia mater were markedly congested.

REMARKS BY DR. FENTON.

The case as reported by Dr. Morton is not only interesting because of its extreme rarity, but because it affords an opportunity for conjoined study by the surgeon and the ophthalmologist. Nearly all the references obtainable by a careful search of the literature of *wounds* of the *optic nerve* have been studied, and no case exactly parallel has been found. The question of main importance in this part of the record is, as to how far the extent of the injury can be determined and the foreign body located by an examination of the eyes. That such examination somewhat lessened the obscurity in this case seems reasonable. The patient gave a very credible history of previous good vision in the left eye, which yet was found to be completely amblyopic; while the right, in which some disturbance was to be expected, was practically uninjured. A valuable observation made by Dr. Claytor, the resident, is that on the date of admission, January 5th, at 7 P. M., the pupils were of equal size, and that two hours later the right was contracted and the left widely dilated. The eyes were in good position, the associated movements were normal, no loss of motility, no impairment of sensibility, no surface anæsthesia, no hypernæsthesia. Externally, then, there was nothing but the inequality of the pupils, and the ecchymosis of the bulbar conjunctiva in the left to serve as a guide. It must be remembered that the first examination which could be secured was made five and a half days after the injury. It is reserved for the opthalmoscope to give some suggestion as to the scope of the injury and the direction taken by the bullet; more especially because the atrophy, though not complete, was clearly of recent origin, and not the result of long-standing disease. This suggested that there had certainly occurred, as stated at the time, a hemorrhage into the sheath, and, in all probability, a nearly complete division of the nerve. This view was further confirmed by an examination made on the morning, and again on the evening of the 14th, when it was found that the vessels were still more thread-like and the optic disk paler; right pupil oval as before, 6 mm., left 8 mm., circular. It seemed quite certain, therefore, that the point of injury was quite well back, because, as Fuchs says; "It is only when the optic nerve has been injured so far forward that the central vessels are at the same time divided that characteristic opthalmoscopic symptoms

can be made out at once. In such cases there develops immediately after the injury a picture analogous to that of embolism of the central artery. The arteries of the papilla and the retina are bloodless, and the retina soon becomes clouded—a sign of its death." As then expressed, the examination of the eyes externally and internally seemed to favor the surmise that the track of the bullet was to the left and upward, rather than backward and downward, although the precise route and the extent of the injury occasioned by its passage could not be determined. The occular state certainly did not suggest trouble at the base. An interesting case strengthening this belief is furnished by Benson: "Perforating gunshot wound of the right eye. Immediate collapse of ball—followed in a few seconds by complete amblyopia of the left eye. Opthalmoscope showed a simple athrophy with no thickening of the coats of the vessels, which were very small. * * * There were no symptoms of central mischief."

It is evident that the most important appearance in this case was the peculiar condition of the optic nerve and retina; although the disturbance of the pupils seemed to indicate some injury to the oculo-motor and the fifth nerve. This lent more credit to the case because, as Mitchell says (*Injuries to the Nerves*): "Muscular injuries of the mortor nerve of the eye which do not at once involve loss of life are rare." It is interesting to add that this quotation is taken from an account given of a case seen by the author in consultation with Dr. Morton, in which he, the author, states that the case stands alone in the history of oculo-motor-nerve esions.

## A FURTHER COMMUNICATION UPON THE USE OF CARBOLIC ACID.

OSCAR H. ALLIS, M. D., PHILADELPHIA.

One of the results of my article on "Carbolic Acid," read before this Society in October last, was the reception of two practical and interesting letters upon the same subject from physicians who were no strangers to the valuable services attainable by the proper use of the drug. By permission of the writers I am permitted to present their views before the Society.

The first is from Dr. D. H. Brodnax, Brodnax, La.

"In 1868 I came near shooting off my right wrist. The explosion of the gun was so near that it set fire to my shirt. I was, therefore, suffering not only from a severe traumatism, but also from a painful burn. Dr. Hart, of Pickins, dressed the wounds and burns with a mixture containing ten per cent. carbolic acid in linseed oil. The pain ceased, and I slept well all night. Dr. Hart remarked as he dressed my wounds, 'You are the first man in Mississippi to have a wound dressed with carbolic acid. This was twenty-five years ago, and during that time I have never found a drug to take its place. Other so-called 'antiseptics,' have been given a trial, and that is all.

"No part of a physicians experience is more valuable than when he is the sufferer; and you will pardon me if I add one other personal experience. In 1880, while soldering a broken tin pipe, I accidentally spilled same molten solder on my hand between the thumb and first finger. I flirted off the mass, about the size of a silver dollar, which took the skin with it and caused most intense suffering. Near at hand stood a bottle of carbolic acid. I took the bottle, and with the cork wet with the drug, smeared the fresh wound. This was too slow business, so I inverted the bottle and poured some of the acid into the wound. As if by magic all pain disappeared, the burning and smarting stopped, leaving a sense of refreshing coolness. What surprised me quite as much as anything else was my ability to finish the work that I had begun with as much ease and unconcern as if nothing had happened. The cure, too, was prompt and uneventful.

"My next case was a woman seventy-five years of age. She had burned the upper surface of the foot so severely by upsetting scalding water, that when the stocking was removed the cuticle came with it. The poor woman was in great agony when I arrived. The raw surface was fully eight inches long by five inches wide. I

took a feather which I had picked up as I entered the yard, and with it spread the undiluted acid over the entire raw surface, and extending the application over the parts adjoining and which were less deeply burned. In a few seconds all pain ceased, and the patient remarked, 'It feels as if cold water was being poured over it.'

"The third application was to a child three years old, who, while at the breakfast table, pulled the coffee-pot over, emptying the contents into its bosom. Its clothing was removed, leaving the neck and breast of the child denuded. I immediately applied the officinal strength of carbolic acid to the raw surface, covering also the unbroken blebs with the same. Pain ceased almost instantly, when the child permitted me to cut the blebs and paint them without a wimper.

"My after-dressing to the burnt surface is very simple. I apply directly to the raw surface absorbent cotton, which I retain in place with a bandage. This is the first and usually the only dressing, for when it comes off the part is healed.

"As my practice has been of a general character, I have not had a large number of any one class of cases, but think that I have used the carbolic acid in at least twenty burns and scalds. Two more cases that I recall may interest you. A man was burned by a jet of steam that skinned the forearm from the elbow to the wrist. The carbolic acid was applied, and with the same result, the man remarking, 'I thought I was in for two weeks, but I'll be at work again in the morning.'

"A child, one year old, got a live coal in the bottom of its shoe. The burned area was the size of a five-cent piece, and deep. The child was nearly frantic with pain. I dipped a small piece of cotton into the pure acid and pressed it into the burned hole. I *counted* eighteen seconds, when the child stopped screaming, and, looking at me, said, 'It done; it has stopped hurting.'

"I always keep the pure crystals on hand; and to them add, when I require their use, just enough water to dissolve them, possibly ten per cent. This is strong enough to remove the skin from healthy parts. I do not add the water to dilute the acid. When it is deliquesced, as it sometimes is, I use it without any water.

"While, probably, carbolic acid has no rival in its curative action upon burns and scalds, its medicinal influence does not stop here. In sciatica I have found that the hypodermatic injection of from five to ten drops of a solution of twenty drops of carbolic acid to the ounce of water carried down to the seat of pain produces almost instant relief. So, too, in carbuncles and boils, I take a solution of from twenty-five so fifty drops to the ounce of water and inject deeply into the inflamed area a couple of drops in three or four places. On the following day the injection is repeated if necessary. The inflamed area is covered with a little absorbent cotton soaked in:

℞ Carbolic acid..... gtt. xxx.
Tannin..... ʒiv.
Aquæ..... ʒij.

By this means the morbid process is arrested and resolution promptly takes place.

"I treat gonorrhœa with injections of the strength of ten drops of carbolic acid to the ounce of water, giving also *per orem* two or three drops three times a day. Cure usually in about three weeks.

I have never but once used it upon a freshly-cut surgical wound, as Dr. Gardner suggests. In this case I removed a urethral caruncle of large size, and which was an obstacle to micturition. After clipping off the growth with scissors taken from the lady's work-box, I immediately applied undilute acid to the cut surface. The pain, smarting, and hemorrhage ceased promptly.

In regard to the use of the deliquesced carbolic acid in burns, Dr. Gardner confirms what Dr. Brodnax claims for it. He says:

"While the Alabama and Chattanooga Railroad was in process of construction, from 1869 to 1874, I, as surgeon to the road, had between five and six thousand men under my care. Among the injuries burns and scalds were frequent and often serious. These would vary in size and depth, sometimes involving the extremities and a large portion of the trunk. One foreman, in particular, had a large part of the back and a lesser amount of the front portion of the trunk, with portions of the legs, seriously burned. On removing the clothing, large portions of the skin came off with it. His condition was lamentable in the highest degree. Morphine was freely

administered internally. On the bed upon which he was to recline, clothes soaked in carbolized oil were laid. Where the blisters were unbroken the carbolic acid applied with a view of toughening the skin. Where blebs were present these were treated to a thin coating of the pure acid, and let alone. The relief was very great It is the only treatment that I have ever used in burns and scalds."

The following is from the pen of Dr. C. J. Cleborne, Medical Director of the U. S. Naval Hospital, Chelsea, Mass. He writes:

"I believe I was the first to use carbolic acid in full strength (Merck's crystals) in buboes, boils, carbuncles, and glandular swellings generally, and can add confirmatory experience of twenty-five years to that of Dr. Gardner's. I made free openings in suppurating buboes, squeezed out the pus, applied the liquified acid to every part, dressed it with zinc ointment, and often in a fortnight the sailor was discharged to duty.

"On one occasion my apothecary on shipboard, who was greatly enthusiastic over the curative effects of carbolic acid upon buboes, injected, upon his own responsibility, nearly a drachm of the melted crystals into the urethra of a marine. *That gonorrhœa ceased then and there*, but that apothecary did not show himself to the marine for a week, for there was murder in his eye! No stricture nor other evil followed, but I should not fancy it would be the favorite injection. I have often used it as an analgesic, painting it over a felon before cutting. Dr. Ashhurst, I think, has used alcohol on cut surfaces after operations; but I think Dr. Gardner must be the first to use *carbolic alcohol*—for that is all it is—so extensively.

"Carbolic acid in a dilute form is readily absorbed. I have detected hydrochianine in the urine of women using carbolic soap in vaginal injections, the urine turning very dark in some cases; but in its full strength I do not think it is ever absorbed. I have used it in hydrocele and in cysts about the neck and jaws, and in no instance have I noticed constitutional effects. The prompt albuminizing of tissues with which the acid comes in contact renders them incapable of absorption. I regard it as the mildest and most superficial of all escharotics. I have known carbolized oil to prevent the healing of ulcers and wounds. In such instances I believe it cuts down the healthy delicate granulations, acting as an irritant. It is often useful as an application in chancroids and venereal herpes. I prefer it to the tincture of iodine as an injection into small cysts. I have injected two drachms into cysts about the jaws. In such, any excess may be slowly absorbed, but I have never known ill effects from its use."

I wish to call special attention to the use of liquid carbolic acid, full strength, or, if the crystals are used, only enough water added to make a solution, as an immediate application to all varieties of burns. Neither Dr. Brodnax nor Dr. Gardner claims originality.*

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POTASSIUM PERMANGANATE, AN ANTIDOTE TO MORPHINE, is the burden of Dr. William Moor's report to the German Clinic, New York. He demonstrated his faith by taking three grains of morphine and immediately swallowing a solution of four grains of permanganate of potassium in four ounces of water. No effects of the morphine could be discovered. The antidotal property of permanganate of potassium for morphine, snake poison, etc., has long been known. Condy's fluid, a solution of permanganate of potassium was recommended years ago for these conditions. Dr. Moor's experiments have been tried in Chicago; unfortunately the dog which was the subject, refused to become affected, even after the hypodermic injection of six grains of morphine but continued lively and frisky, until the patience of the investigators was exhausted.

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**Soothing Syrup Without Opium.**

℞ Ol. anisi ..... ♏ xxv
Alcoholis ..... ℥ij
Fl. ext. valerian ..... ℥j
Ol. menth. pip. ..... ♏ xv
Tinct. camphoræ ..... ℥ij
Fl. ext. glycyrrhizæ ..... ℥ij

M. Sig. Shake the bottle. Dose, one-fourth to one-half teaspoonful in water, repeat as needed.

—*The Doctor.*

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**Scrofula**

℞ Ol. morrhuae ..... ℥iij
Syr. calcis lactophosphat. ..... ℥ij
Syr. ferri iodidi ..... ℥iij

M. Sig. Teaspoonful three or four times daily.

—*Ex.*

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* Dr. Charles W. Dulles, author of "What to do First in Emergencies," and who is familiar with the literature upon the treatment of burns, says that he has "never seen any mention of the use of the undilute acid as a topical remedy."

# TRANSLATIONS.*

## THE TREATMENT OF CHRONIC CONTRACTIONS OF THE KNEE AND HIP-JOINT BY TENOTOMY OF THE TENDON OR MUSCLES.

The author, J. Wahncau, reports eight cases treated by him, in which the contractions were due, respectively, to articular rheumatism, disseminated cerebro-spinal-sclerosis, infantile paralysis, spinal origin muscular atrophy, acute poliomyelitis, and traumatic inflammation of the knee-joint. In chronic cases of extensive myopathic contractions, in which the extension apparatus, or all other local treatment remain unsuccessful, Schede has practiced a free transverse separation of the shortened soft parts, his method being as follows:

For instance, in a case of shortening of the lower extremity, he makes a longitudinal incision on one side of the tendon of the biceps, the other, along the tendon of the semi-membranossus and semi-tendinosus at the point where they seem most tense in the popliteal space, of about seven or eight centimetres. All the tense soft parts between these two incisions, minus the large blood vessels and nerves, are then divided transversely, and the knee stretched, the wound dressed antiseptically and kept moist, which usually heals in the space of three to four weeks.

The author emphasizes the importance of moist dressing in wounds of tendons, this affording the most favorable means for repairing defects in such structures. In all the above mentioned cases, of which the author gives a detailed account, the results were all that could be wished. In three cases tenotomy was performed at five different places, the results being perfect. —*Centralb. für Chirur.*, 1894. —W.

## STRUCTURAL CHANGES IN THE KIDNEY FOLLOWING NEPHROTOMY.

Dr. A. Barth reports (*Archiv. f. Klinisch. Chirurg.* Bd., 46, Heft II., p. 418) the case of a woman, æt. 31, who was presumably suffering from tubercular disease of the right kidney. Exploratory nephrotomy was performed September 14, 1892. The expected changes in the pelvis or parenchyma of the kidney were, however, not found, the incision in the kidney was closed as also the external wound. There was continued rise in temperature, accompanied with violent pains in the region of the right kidney; the urine contained bacilli of tuberculosis. Thirty-four days after the first operation, October 18, 1892, the right kidney was extirpated; it was deeply imbedded in hard callous-like tissue. The microscope showed a thin cicatricial line extending into the hilus, where the incision had been made. In the centre of the kidney close to the cicatricial line, a wedge-shaped necrotic deposit was seen, and on the opposite side of this line a narrow zone of absolutely dead tissue could be defined.

On the line of demarcation between the living and dead tissues there was a distinct line of interstitial growth.

The larger necrosed portion, almost triangular in shape, still retained many of its canals and cells apparently intact, but not susceptible to coloring matter; in the outer zone the parenchyma was dead. The stroma and cells were surrounded by a fatty detritus. The cells were leucocytes, undergoing retrograde changes, some seemed filled with fatty globules. Isolated leucocytes were found in the uriniferous tubules and the glomeruli. A third zone consisting of an increase in connective tissue formation, in which there was also destruction of the canals and glomeruli, either homogeneous or granular. Here could be seen columns of cells seemingly connected with the uriniferous tubules, and suggesting the formation of new canals. Some of the destroyed tubules and glomeruli had retained their outer

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D., and F. H. Pritchard, M. D.

form, but seemed filled with fine tissue, not unlike connective tissue.

In the center of the wedge-shaped necrotic deposit, the vessels and canals were filled with a fine fibrinous network. Some isolated crystals of haematoidin were found in the destroyed blood-vessels.

The author justly calls attention to the similarity between this picture and cases of infarction due to emboli. The cases are the same with one exception, that in his case it was due to an injury of the artery, instead of an embolus.

In spite of this experience, the author still insists that the incision made by him is the best, since all others will lead to still greater destruction of blood vessels.

—W.

## TUBERCULAR PLACENTA.

Lehman demonstrated at the Berliner Medizinische Gesellschaft (Berl. Medical Society) a placenta, which showed tuberculous changes in the villi of the chorion. The deposit was of gray, partially yellow color, transparent, round and contained tubercle bacilli.

The patient was highly tubercular, and gave birth to a child, which died on the tenth day without showing any symptoms of tuberculosis. This may prove a solution of the question as to infection of the fœtus.—*Deutsche Medizinische Wochenschrift.* —M.

## ŒDEMATOUS SWELLING OF THE PREPUCE ACCOMPANYING THE USE OF ANTIPYRINE.

Dr. Freudenburg reports: Male, thirty years old, took seven-and-half grains antipyrine for headache. No relief; an hour later felt a burning sensation in the urethra and considerable itching of the prepuce, and behind the scrotum. Considerable swelling of the prepuce and the glans were noticeable.

Freudenburg administered the same patient some four weeks later and again gave seven-and-a-half grains antipyrine to verify the supposed effect of this drug. Two hours later, the same symptoms as stated were observed.—*Centralblatt fuer Klinische Medigin.*

—M.

## GANGRENE OF PENIS FOLLOWING INFLUENZA.

Dr. Devriant observed a case of influenza, which developed gangrena penis on the fourth day of the disease. Patient, forty-one years, had a very severe attack of influenza. On the second day he noticed a redness and swelling of penis. On the third and fourth day buboes were developed. Patient denied positively venereal infection or traumatism. Neither gonorrhœa nor chancre present. Urine was clear, no albumen or sugar being present.

The treatment consisted of elevation and leadwater solutions for the pain.

On the fourth day a large gangrenous bulla developed on the point of the glans, which extended in a few hours over one third of the penis. On the following day (fifth) the gangrenous mass was removed. This mass extended to the fibrinous sheath of the corpora cavernosa. The urethra was healthy, the veins in the gangrenous mass were filled with thrombi. Thorough removal of the gangrenous portions and antiseptic dressings cured the patient in eight weeks.—*St. Petersburger Med. Wochenschrift.* —M.

### Urticaria of Children.

℞ Chloral hydrat.,
Comphoræ pulv.,
Acaciæ pulv.,.....aa 5j.
Triturate till liquefied, then add
℞ Cerat. simpl.,..... 5j.
M. Sig. Apply topically.

—*Canada Med. Record.*

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.

### INALTERABLE FOWLER'S SOLUTION.

Dr. Brautigam (*La France Medcal* , No. 2, 1893) proposes the adoption of Traube's formula in the preparation of Fowler's solution. It yields an unalterable preparation. One gram (fifteen grains) of arsenious acid is dissolved, by boiling, in five c. c. (℥j¼) of caustic potash, the solution is then diluted by adding thirty grams (℥j) of water, forty grams (℥j¼) of alcohol and five to ten grams(℥j¼—℥ijss.) of essence of peppermint. Finally, enough alcohol is added to make 100 gms. (℥iijss.) The dose is from ten to fifteen drops in twenty four hours.

### STATIC ELECTRICITY IN CHOREA.

Dr. R. Verhoogen (*Revue Internationale de Biblographie*, No. 22, 1893) reading the results which Dr. Courjon of Lyons, had obtained with static electricity in the treatment of two cases of chorea, in children where the disease had but recently appeared and where the writer had obtained almost immediate and lasting results, determined to try it. He had under his observation two typical cases, and, from his results he can completely confirm Courjon's recommendation. It succeeded where the usual means of treatment failed, and though the number of patients treated was small, he thinks it deserving attention.

### STRYCHNINE IN SNAKE BITES.

Dr. Smith (*Australasian Medical Gazette*, No. 11, 1893) reports the case of a boy ten-and-half years, who being bitten by an extremely venomous serpent, was cured by subcutaneous injections of strychnine, even after bloody vomiting, a semi-comatose state following convulsions, collapse and small pulse announced approaching death. The effect of the injections was immediate, for the next day he was up and about and able to work.

### GRINDELIA ROBUSTA.

Dr. Jasiewicz (*Le Mercredi Medical*, No. 49, 1893) states that this drug is easily taken in any preparation and it may be prescribed in elevated doses, yet it is best to give it in broken doses, on account of its slight toxicity. A very large dose at one time might be fatal. It causes a mild sensation of warmth in the stomach, slows the respiratory and cardiac movements, dilates the pupils and induces sleep. It has a slightly acrid and pungent taste. It is especially indicated in respiratory neuroses, asthma, especially the spasmodic form, whooping cough and similar coughs, nervous cough, hay fever and emphysema. It acts favorably in acute bronchitis, but it must be taken for considerable time. In chronic bronchitis it is less satisfactory. In whooping cough antipyrine acts better as a sedative though grindelia may be administered, on the contrary, much longer, without fear of unfavorable consequences—a considerable feature in a disease requiring so long treatment. Though it decreases the violence of the cough it does not shorten the duration of the disease, for this disease is not a respiratory neurosis but an infectious disease, requiring antiseptics, antispasmodics and tonics.

In asthma it is more active. It calms the dyspnœa, prevents its return, but does not ultimately remove the disease. Here the iodide of potash is most efficacious in this latter respect. It is a precious remedy in spasm and has been found of value in stridulous laryngitis. Externally, Dr. Bardet has found it of service in vaginitis, genito-urinary catarrhs and burns. Dr. Bocquoillon recommends it in the itching of skin diseases. There is a certain resemblance, therapeutically, between it and belladonna.

### SULPHIDE OF SODA IN LEAD POISONING.

Drs. Peyraud and Quinquad (*Le Mercredi Medical*, No. 49, 1893) have experimented on animals and persons, poisoned by lead, in order to determine the best means of assisting the elimination of lead from the organism. The good effects of the chloride of soda were already well known to them and they can confirm this action from their experiments but they find the sulphate to exercise a still more energetic influence. It acts the same upon mercury as lead.

### RHEUMATISM IN CHILDREN, AND ITS TREATMENT.

Prof. Jules Simon (*Le Bulletin Medical*, No. 97, 1893) states that in children it chiefly appears between five and thirteen

years, and contrary to what he observed in adults, attacks only one joint. The swelling is more pronounced and not only the synovial membrane but all the tissues around the joint are inflamed. The fever is generally only moderate and rarely reaches the height that is seen in adults. In the morning, sometimes it falls one to two, or even two and a half degrees. Endocarditis and pericarditis are observed more frequently than in adults but do not assume the dangerous character; often lasting two or three days, and even if peristing for some time rarely being followed by the consequences seen in later life. In children compensation is much easier. It rarely becomes chronic. Muscular rheumatism in children chiefly affects the sterno-mastoid muscle and the contiguous parts, often simulating an attack of tonsillitis, and is mostly associated with inflammation of the atlanto-occipital articulation, which is characteristic of youthful age. Yet other regions as the upper arm, thigh and buttocks may also participate. In acute articular rheumatism, rest in bed is above all things indicated, then warm aromatic beverages and milk. To the affected joint and its surrounding region, the following liniment may be carefully applied:

| | | |
|---|---|---|
| Extract of bellandonna..... | 2 gms. | (grs. xxx.) |
| Oil of hyoscyamus..... | 15 " | (3iv.) |
| Oil of chamomile..... | 30 " | (3j.) |

Over this apply a layer of cotton batten, so that the joint is in a permanent sweat bath. Internally, the best remedy is the salicylate of soda, but if it is not tolerated, try the sulphate of quinine. Do not begin immediately with large doses. The first day one may prescribe seven and a half grains, the next day twenty-two grains and so on up to forty-five, or at the most fifty grains. On the second day after the maximal dose, gradually decrease to a daily dose of twenty-two grains. Even after recovery—in children it lasts, as a rule, fourteen days—continue the drug for eight to ten days at twenty-two grains per diem. If the disease becomes chronic, employ massage and electricity, the constant and weak current. Internally, together with tonics, one should employ the tincture or some other preparation of colchicum, which is of great service in the chronic form. For eight days, give ten drops of the tincture, before going to bed, then discontinue it for eight days and so on to complete recovery. In the intervals, one may use the iodide of potash, which, of itself, is not as active as colchicum. He warns especially against sending such children to the sea-shore or damp regions.

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### SALT WATER IN ACUTE ANEMIA.

Dr. Ostermann (*Muenchener Medicinische Wochenschrift*, No. 2, 1894) reports that in Martin's Private Hospital, in Berlin, he has obtained very favorable results with infusions of salt water in acute anemia. Hypodermic injection is especially recomended. The needle is introduced into the subcutaneous tissue in the vicinity of the mammary gland or in the intraclavicular region, the water allowed to flow in from an ordinary irrigator, with continuous massage in the direction of the needle. In this way one may inject in a few minutes from two to three hundred grams (six to ten ounces) and repeat the injection, in a short time, if necessary. At the same time one should employ stimulants, ether, musk or camphor, subcutaneously.

If the heart be especially weak, one may aid it with artificial respiration. The solution is to be injected, prophylactically, in every anemic person where an operation is necessary and, obstetrically, in placenta previa.

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### FREQUENTLY RECURRING EPISTAXIS.

Prof. Cozzolino (*Bulletin Medical*, No. 101, 1893) rejects the use of the perchloride of iron and advises the employment of a solution of trichloracetic acid, in distilled water; 1 gm.: 30–40 gms. of distilled water. A tuft of cotton is wound around a splinter of wood and the solution applied directly to the cartilaginous septum whence the hemorrhage generally comes. In order to prevent the disagreeable sensation of burning, one may add a little cocaine or better tropacocaine. The remedy acts rapidly, a scab forms on the cauterized spot which falls off and the wound heals.

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### GARGLE FOR SIMPLE TONSILLITIS.

In *Revista Clinica Terapeutica*, (No. 12, 1893) the following formula is recommended in simple tonsillitis:

℞

| | |
|---|---|
| Borax, | 6gms. (3iss). |
| Tinct. of Benxoin, | 15gms. (3iv). |
| Rose Water, | ad 130gms (3vss). |

Gargle frequently with this mixture.

# BACTERIOLOGICAL NOTES.

## STREPTOCOCCUS IN PERNICIOUS ANÆMIA.

An interesting case of pernicious anæmia and its causes is reported by Fischel and Adler (*Zeitschrift f. Heilkunde*, No. 4, 1893). A patient who had contracted a slight wound in the left heel some months previous to the examination was admitted to treatment on account of anæmia. The blood corpuscles were abnormal in number and other symptoms were present which led to the diagnosis of pernicious anæmia which resulted in death. An hour before death the blood for the first time was examined for bacteria and chains of streptococcus were discovered. A few minutes after death cultures were made from the blood. The *post mortem* examination confirmed the orginal diagnosis. The cultures developed streptococci which resembled *streptococcus pyogenes* very closely, It was pathogenic for mice. The author thinks that the anæmia was the result of the streptococcus which gained entrance at the time of injury of the foot and which had developed a chronic case of septicæmia. The argument is that the toxic products of the germ causes a deterioration of the blood which enables the streptococcus to enter the circulation and produce the somewhat rapid fatal results. To support this view they experimented with sterilized cultures of the streptococcus on rabbits which resulted in the diminuted red and white corpuscles and, finally death, of the animals. The author lay much stress upon the importance of bacteriological examination of the blood early in the course of such of troubles. They also point out the difference in the nature of the disease which they studied, the deterioration of the blood corpuscles, and the septicæmia usually produced by these bacteria.

## THE ETIOLOGY OF PERITONITIS FROM PERFORATION.

The exciting cause of peritonitis even when induced by perforation of the intestine has been attributed to many causes, but the doubt that is entertained concerning the exact factors gives the results of certain definite investigations of the subject considerable interest. Barbacci (*Centralblatt f. Allgem. Path.*, Bd. IV., No. 19) gives the results of his study of fourteen cases of peritonitis produced by perforation. In addition to these cases he has made several experiments on animals. The conclusions which he has reached are of special interest. They are as follows:

1. Cultures made from the peritoneal exudate in cases of peritonitis from perforation in man, develops usually only a single species of bacteria—*bacillus coli communis*. Occasionally, however, diplococcus lanceolatus capsulatus (Frænkel) can be shown to exist in the exudate by the inoculation of mice and rabbits.

2. By artificial perforation of the intestine in the dog an affection precisely similar to that following the perforation in man may be induced.

3. In both man and dog only one organism, *bacillus coli*, is found in cultures from the peritoneal exudate although the latter may be found to contain very varied organisms.

4. After the entrance of the fæcal matter into the peritoneal cavity, the various bacteria therein contained develop equally with *bacillus coli* during the early stages of the inflammation which is induced. But subsequently they die, whereas *bacillus coli* continues to thrive and thus is susceptable of further cultivation.

5. No efficient cause for the death of microbes can be assigned. Experiments do not support the theory that they succumb to *bacillus coli* in the struggle for existence.

6. In a number of cases one finds bacillus coli in the heart blood of persons who have died of perforation peritonitis. In others it is not to be found there; and this, coupled with the fact that it is absent from the blood of the dog when the necropsy is performed shortly after death, renders it probable that, in the first men-

tioned cases, the entrance into the blood stream took place *post-mortem*.

7. The diplococcus lanc-capsulatus is never found in the exudate in cases of the dog, and as it is also absent in many of the human cases, one may conclude that this organism does not play an important part in the pathogenesis of the perforation peritonitis.

8. As regards the course and termination of the disorder much depends upon the amount of time which has elapsed since the preparation. If the aperture of communication can be closed inflammation of the peritoneum may be checked, even though far advanced, and complete recovery will then be secured.

10. The intestinal gases which pass into the peritoneal cavity with the feces play a not inconsiderable part in orginating and perpetuating the peritoneal inflammations.

11. The latter is due to two co-operating causes, each of which is by itself self imperative, namely, its extravasation of feces and of gas and the development of the germs contained in the former. The inflammation is perpetuated by the continuous irritation of the extravasated matter.

12. Death in cases of peritonitis from perforation is due to an intense intoxication of the organism that results from absorption of the fluid and gaseous contents of the bowel and the toxic bacterial secretions.

## DIPHTHERIA.

The importance of pseudo-diphtheria bacillus, its relations to the Klebs-Loeffler bacillus, and the efficiency of antiseptic treatment of diphtheria have all been matters of careful investigation, and still remain questions of interest. Kossel, *Deutsch Med. Wochenschrift*, No. 46, 1893) has brought together the results of certain recent investigations in these lines which are quite interesting. It is now generally considered that the pseudo-diphtheria bacillus is only an attenuated form of Loeffler's bacillus, and that it may regain its virulence. The virulence of the diphtheria bacillus depends on the alkaline reaction of the boullion in which it is cultivated, on the age of the culture, on the size of the animal, and on the place of injection. The production of the diphtheria poison dependent at first only on the original virulence of the culture and the alkalinity of the medium in which it is cultivated. Oertel differentiates two kinds of membrane: (1) small greyish, white or yellow points of of deposit, which later become confluent and spread to adjacent parts; and (2) in addition to (1) an œdematous swelling of a tissue, which is dull in appearance and remains smooth. This dullness extends into the deeper parts, and the epithelium, also assumes an opaque color. When this is detached it bleeds, this is malignant diphtheria. Leucocytes may accumulate in the deeper layers of the tissue and produce necrotic areas which may ultimately rupture on the surface.

*Treatment:* Antiseptics are applied in the first case in the form of spray (2 to 6 per cent carbolic acid) every two hours. In the latter case caustics should be avoided. Decomposition of the membrane should be guarded against. The surface should be swabbed with carbolic solution after the removal of the membrane. The internal use of potassic chlorate is not recommended, but mercurial salts may be tried.

Klebs has endeavorod to find a specific treatment (*British Medical Journal*, 1893, p. 1070, Nov.) but Kossel thinks that in the absence of bacteriological proof some of his cases might not have been true diphtheria. Klebs answers this, and states that they were genuine cases and adds that he has since treated forty new cases with only four deaths.

[Some time ago Dr. Robert Reyburn, of Washington, D. C., published an article in the *Medical Record*, in which he reported several cases of successful treatment of diphtheria by the use, locally, of a strong solution of mercuric chlorid. He used as high as 1 to 500 solution. His cases, were in part, demonstrated diphtheria, as the Klebs-Loeffler bacillus was found in the membrane. He administered mercury salts as well as applying it locally, but he attributed his success to the antiseptic treatment.—*Ed.*]

# THE MEDICAL AND SURGICAL REPORTER

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SATURDAY, MARC 10, 1894.


## EDITORIAL.

### THE EFFECT UPON THE NURSLING OF THE MOTHER'S DIET.

The feeding of infants on artificial foods is a growing evil for which, although they inveigh against it, physicians are in a large degree responsible. Efforts are made to explain the evil away on such grounds as the desire of the mother to avoid the inconveniences of her natural duties, or of changed conditions of life causing inability to furnish food in sufficient quantity, if at all, or of deficient quality of the mother's milk, or other conditions, for all of which the mother is responsible. These conditions do exist in a greater or less degree, but aside from actual and acute disease, the maternal conditions may be tersely summed up in the statement that the mother is unwilling to make the sacrifices necessary if she performs her duty to her child. The responsibility of physicians lies in weakly conceding to the patient's desires, in place of strenuously insisting upon the mother's every effort to carry out the provisions of nature.

In these days of milk-foods, prepared foods, substitutes for mother's milk, etc., etc., mothers do not understand that the nature which provides organs for bearing children, also provides organs for nursing children, and intends that these organs should be for use rather than ornament. She does not realize that the products of modern science at best, are but poor substitutes for the products of nature. If the physician would insist upon the mother performing her natural functions despite her assertions that she 'cannot nurse the child,' 'never could nurse her children,' 'didn't have milk enough,' 'nipples too small or too tender,' or 'milk left her in two or three months,' etc.—if the physician should insist, and the mother persist, both would be surprised to find that long abused nature would still be willing to do her proper work.

Patient endurance of discomfort, persistent effort and proper food will eventually demonstrate the ability to nurse their infants, in nine out of every ten mothers who assert the necessity, in their individual cases, for "bringing up the baby on the bottle." And that, too, without scouring

materia medica for imaginary galactagogues, and likewise to the very great benefit of both mother and infant.

During his six years' service at the Preston Retreat, Dr. Joseph Price gave the medical profession, through that institution, some most valuable object lessons in obstetrical science.

There was no secret in the methods used to make that institution the model maternity of the world so far as professional results are concerned. His guiding principles were *care*, *cleanness*, and *common sense*. The strictest supervision of every detail, scrupulous practical cleanness and not so much of theoretical cleanliness, and simplicity in all matters, enabled him to complete his service with a mortality record never equalled in private or public maternity work.

It was a law with him "to allow the mother to bear her own children," and it was equally the rule to require each mother to nurse her own infant during her stay in the institution. So very rare were exceptions to this rule necessary, that a nursing bottle could not be found in the entire institution. The patients in the Retreat were in no respect an exceptional class, save in the fact that so large a proportion of them were ill-nourished and impoverished in physical health when they entered the hospital — conditions which would entitle them to claim inability to nurse infants. Another fact of interest was noted, namely, that many mothers, who while in the house furnished abundant food supply and left the institution with thriving babies, would, after leaving, put the baby on the bottle as a matter of personal convenience, and in a surprising proportion of such cases, would lose the babies within a few months.

The moral to be drawn is that almost every woman who can bear a child can nourish it. Attention to the body functions, generous supply of simple, nourishing food, and early and persistent efforts to establish and develop the mammary secretions were the only methods used to secure these results.

In general practice the physician is too apt to give up the contest too early or to rely upon some form of stimulant to the glands, which eventually proves delusive if not injurious. It is a common practice to administer alcoholic beverages in the form either of ale, beer, or porter to nursing women for the purpose of increasing the milk supply. Beyond question these articles are capable of doing much injury to both mother and child, and their indiscriminate employment for such purposes should be interdicted.

Dr. J. W. Byers, in the *Annals of Gynecology and Pediatry*, has made some very pertinent remarks on this subject. He says: "The truth is, in this practice of using alcoholic drinks the profession has followed the customs and whims of the laity, rather than the usual process of instructing and leading the latter. That there are conditions and circumstances in which the administration of malt liquors is of decided benefit to both mother and child, no one will undertake to gainsay. But that they are indicated in every instance of deficient lacteal secretion, or that the exigencies of the case ever render necessary their use to the extent as is commonly employed, none can maintain or justify. The promiscuous and general practice of using malt liquors by nursing women is irrational, does a vast amount of harm, and often causes disease in the suckling. We know that the mammary gland, for all practical purposes, may be considered as an organ possessing functions of a twofold or mixed character, namely, secretion and excretion. Under normal physiological conditions the first of these processes is in almost exclusive operation, though, is shown by experiences, the slightest alteration in the condition of the organism, whether of an emotional, medi-

cal, or dietetic character, may so change this secretion that it becomes to all purposes and effects an excretion, and an innocuous, healthy pabulum for the child is converted into a deleterious or poisonous substance."

"Experience is very general in showing that the milk fats and albumins, in increased proportions, have a decidedly injurious effect upon the digestion of the infant when taken into the stomach in excessive quantities. From a number of experiments conducted by Zaleski he found these substances in the milk in excessive proportions whenever the mother had partaken of alcohol. In each case where the mother was tested with malt liquors, the fat and albumen appeared and caused more or less disorder and distress of the digestive apparatus of the suckling. These deleterious influences, however, were not the worst. Analysis of the milk further revealed the fact that it actually contained alcohol and the micro-organisms peculiar to malt liquors; that the liquor drank by the mother actually passed out *in toto* through the mammary gland and on into the child's stomach, and there produced all the phenomena incident to digestive disorders and febrilê disturbances. These facts point to the belief, and support the attitude, that the mammary gland under certain conditions exercises the function of an excretory organ, and that under some circumstances it becomes nothing more than a filter through which the food and drink taken by the mother, passes directly into the stomach of the child. This being true, we are in a position to understand and appreciate the importance of the relation of the diet of the mother and the well being of the child. When we prescribe alcohol for the mother, we at the same time do so for the child."

"The diet of the mother is a stage in the milk-producing process, and the milk she produces, is, in every instance, the result, and only the result, of the food of which she partakes. If it be improper, unsuitable, or contaminated, the milk will express this in a proper ratio. In the case that beer or ale is administered it will find this outlet, and while it does not evidence deleterious influences to the extent of producing the worst results in the form of either colic, indigestion, or diarrhœa, in every instance its effects are present, and these are always among the possible results of its use. The effects of fat and albumin, when present in breast milk in excessive proportions, in producing evil effects on the child are too well recognized to dwell upon. That the more severe of stomach disorders, gastro-intestinal catarrh, enteritis, or even cholera infantum, are due to these substances, as a result of the abuse of malt liquors in the mother, is certain, though such is not generally admitted or recognized."

"Take care not to advise a woman, whose milk supply is reasonably full, to resort to beer or other liquors in order to increase it. Always impress upon them the increased risk to the child incurred by using them."

---

**Change of Meeting Place.**

In view of the fact that the largest and best hotel in Gettysburg was burned a short time ago and will not be rebuilt in time for the meeting of this Society, it was deemed best after consultation with the Board of Trustees to change the place of meeting; and as the Philadelphia County Medical Society extended an invitation for this Society to meet in Philadelphia, this was accepted.

The Medical Society of the State of Pennsylvania will, therefore, hold its Forty-fourth Session in Philadelphia, May 15, 16, 17, and 18, 1894.

H. G. McCormick, *President.*

Wm. B. Atkinson, *Secretary.*

# ABSTRACTS.

## IMPERFORATE ANUS, WITH RECTO-VAGINAL FISTULA IN A PATIENT NINTEEN YEARS OF AGE.

Mr. Henry Thompson reports a case of a patient, who was sent to the Hull Infirmary on September 25th, 1893. The mother stated that the girl was a week old before the nurse found out that there was any malformation. When five or six weeks old, Mr. Thompson, of Beverly, "tried to make a proper opening," but failed to do so. When fourteen months old she was brought to the Hull Infirmary and examined. Nothing was done, but the mother was advised to bring her again when fourteen or fifteen years old. During the whole of her life of ninteen years, the girl has never had control over defecation, but during childhood she had relief without the administration of an aperient, although the mother stated that up to admission to the Hull Infirmary she had never known her to pass a "formed" motion. Seven or eight years ago she began to suffer from attacks of "sickness and purging." At first these attacks only occurred at intervals of three or four months, but latterly there had been only, as a rule, an interval of a month or so.

During these attacks she had stercoraceous vomiting and constant passage of fluid motions. The patient had never menstruated, but had always been an active intelligent girl. On admission to the hospital she appeared more like thirteen instead of ninteen years; there was an absence of an anus, its site was marked by a cicatrix.

The hymen was absent, the vagina capacious. Just within the vagina on its posterior surface, a round aperture could be felt communicating with the rectum, which was felt to be loaded with a huge accummulation of fæces, which probably extended through the whole of the large intestine. On October 7th, the patient was anæsthetised, the lower bowel cleared, and the following operation performed: A combination of Mr. Whitehead's for severe hemorrhoids and Lawson Tait's splitting oporation for ruptured perineum. The rectum being plugged through the vaginal fistula. A verticle incision was made from the apex of the perineum to the tip of the coccyx and continued down to, but not at first dividing, the mucus membrane of the rectum. The rectum was then freed for some distance from its attachments so that it bulged into the upper part of the wound like the end of a sausage. Anteriorly each side of the vaginal fistula was split and the posterior wall of the vagina was dissected up from the anterior wall of the rectum for some distance beyond the upper end of the fistula.

After continuing the original vertical incision through the mucous membrane of the lower end of the rectum seven sutures were inserted, attaching the edges of the edges of the freed rectum to the edges of the skin, so as to form an anus. These were not tied until the vagiual fistula had been sutured. Commencing at the apex of the vaginal fistula, a small threaded, right-angled needle was passed through the mucus membrane on one side from before backward, then catching the other side from behind forwards, so as to bring together the anterior one and a half inches of the fistula. A strong handled threaded curved needle was then passed, first within the split edge of the fistula on one side, and then within that of the other side. This was done in three places, and all the stitches then tied, first those of the vaginal fistula, then those around the new anus. All that remained to be done was the insertion of numerous superficial stitches in the perineum and behind the new anus. The result was good, except the difficulty in expelling the bowel contents, that power having never been developed, but abdominal massage with aperients have produced an improvement and it is probable that the muscular power will develop and she may be able to have natural evacuations without any aid. —*Lancet*, Feb., 1894, pg. 403.

[The operator is certainly to be congratulated upon the carefully studied method of operation as well as the excellent result —Ed.]

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

## THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY.

for February. Dr. Richard C. Norris reports

**A Case of Symphysiotomy.**

The pelvic measurements of the patient were as follows:

| | |
|---|---|
| Inter-splnous | 19½ cm. |
| Inter-crestal | 20½ cm. |
| Diagonal | 19 cm. |
| Circumference | 70 cm |
| External conjugate | 16 cm. |
| Inter-trochanteric | 27 cm. |
| Diagonal conjugate | 9 cm., scant. |
| Estimated conjugate | 7 cm., scant. |

After repairing the vaginal and perineal lacerations, the index finger was inserted in the abdominal wound, and the anterior wall was pushed back as the cut surfaces of the symphysis were allowed to come together. The abdominal wound was then closed with silkworm-gut sutures, and the usual firm binder applied around the pelvis. The diameters of the child's head were as follows:

| | |
|---|---|
| Bitemporal | 8 cm. |
| Biparietal | 9¼ cm. |
| Occipito mental | 14½ cm. |
| Occipito-frontal | 12 cm. |
| Trachelobregmatic | 9¾ cm. |
| Occipito-frontal circumference | 32 cm. |

The child, a female weighed eight pounds, was still born.

The patient's convalescence was uneventful until the third day, when cystitis developed, followed by incontinence of urine, which contained an abundance of pus and numerous tube casts. The patient had been catheterized, without any special care as to chemical cleanliness, by one of the physicians who saw her before the author's visit. She also required catheterization after delivery.

The cystitis under appropriate treatment gradually improved, and at the time of discharge from the hospital there was no incontinence of urine and only a small amount of pus. On the fifteenth day the patient developed mania; beginning as a condition of mild hilarity with irrepressible loquacity. The highest temperature during her five week's stay at the hospital was 101°, the average being 99° Her weight upon leaving the hospital was seventy-six pounds; her height, five feet three inches.

The points of interest in the case are:

(1) The prolonged labor, about ninety hours, which is believed to be the longest period of labor in any case upon which symphysiotomy has been performed in America.

(2) The difficulty in accurate estimation of the conjugata vera in any case of flat pelvis, a difficulty, the author believes, more readily overcome by Hirst's modification of Skutch's pelvimeter than by any other means at our disposal.

(3) The degree of separation at the pubic joint, which was not more than one inch.

(4) The prompt appearance of cystitis following the use of an unclean catheter in a bladder which had been subjected to prolonged compression and perhaps contusion.

(5) The development of so-called puerperal insanity.

Dr. George J. Engelmann contributes a paper on

**Vaginal Hysterectomy,**

considering especially hysterectomy by morcellement and the vaginal route in certain pelvic operations in place of laparotomy or the abdominal method. In opposition to his formerly expressed opinion, he now says that in cases which can often not be completed by the laparotomy, when inflammation has preceded, when suppurative salpingo-ovaritis and peritonitis complicates the case, when extensive adhesions exist, that the vaginal operation is indicated; and in extreme cases, in purulent bilateral salpingo-ovaritis with adhesions, matting together of intestines and omentum, and multiple pus centres, the vaginal route is preferable if not imperative, and abdominal section is relegated to simple non-adherent cases, admissible in suppurative forms only if unilateral or if distinct enucleable centres exist.

The vaginal method takes the place of cœliotomy for the following operations on the pelvic viscera:

(1) Hysterectomy proper for malignant disease of the uterus, carcinomatous, sarcomatous, or adenomatous; for benign tumors, fibromata and myomata, not extending above the navel; painful metritis or hemorrhagic endometritis resisting treatment; for otherwise ungovernable cases of prolapse or inversion. These are now generally-accepted operations. The novel features are:

(2) Hysterectomy for bilateral suppurative disease of the appendages, with accompanying disease of the uterus.

(3) All forms of pelvic suppuration and inflammatory deposits.

(4) Removal of the diseased appendages of one side only.

(5) For minor operations, the breaking up of adhesions, replacing and fixation of the uterus, and for purposes of examination.

The advantages of the vaginal route for all pelvic operations to which it is applicable are: the proximity of the parts to the hand of the operator; the possibility of controlling the work of knife and scissors by the eye; the rapidity of operation, which is made by the absence of ligature or suture; the absence of hemorrhage by the application of forci-pressure before section; the avoidance of the peritoneal cavity proper to a more or less marked extent. To this he mainly attributes the absence from shock which is claimed for these operations. No visible cicatrix is left, and the possibity of ventral hernia, which is not infrequent after the abdominal operation, is avoided. Injuries to the viscera can be as readily remedied as during operation by the abdominal incision, but they rarely occur, as the intestines are not likely to come into view.

The one objection is the necessarily small field of operation, the smallness of the opening, which would limit the opportunities for this method were it not for the possibility of *morcellement*, which admits of the successful removal of large fibroid tumors extending as high as the umbilicus, or of fibroid tumors and inflammatory masses almost filling the pelvic cavity.

The vaginal operation appears to the author as the operation of choice in cases of extensive inflammation and suppuration, and whenever practicable it should be resorted to, by reason of its simplicity and rapidity and on account of the avoidance of the abdominal cavity. The very adhesions which form an obstruction in our efforts to reach the pelvic viscera by abdominal incision, the matting together of intestines and omentum, are a protecting guard against that dangerous cavity in operations by the vaginal route.

Hysterectomy by *morcellement* also affords a far greater probability for a cure for pyosalpinx of gonorrhœal origin, a cure which would appear probable or possible only by this method of operation, because it admits of, if it does not necessitate, the removal of the uterus as well, and he believes that removal of that organ in these cases is a necessity, that the imperfect results which accompany so many of the so-called successful operations for pyosalpinx and pelvic suppuration by the abdominal incision are due to the leaving of the uterine body; within the uterine mucosa and the remnants of the tubes is left the nidus of disease, and a cure, a restoration to health by the mere removal of the larger pus centres is improbable.

The method of performing the operation, its technique, the instruments required and the after treatment of the patient are all described by the author.

Dr. Charles P. Noble discusses

**Procidentia Uteri.**

Among the causes of the condition he gives tight lacing, from its interference with the proper position and motion of the viscera; the loss of pelvic adipose tissue from some sudden wasting disease or at the time of the menopause. Retro-displacement of the uterus and increase in its size and weight are also given as causes, though in his experience by far the most common is laceration of the pelvic floor, especially lacerations involving the levator ani muscle and pelvic fascia. In regard to the treatment, he advises immediate restoration of a torn perineum following labor. He believes that the practice of putting in two or three sutures from the skin perineum cannot be too strongly condemned, because all severe lacerations extend two or three inches up one or both sulci of the vagina, and cannot be reached by sutures introduced from the skin perineum.

In those cases complicated by supra-vaginal elongation of the cervix he operates by doing a high amputation of the cervix, anterior colporrhaphy, and Emmet's perineorrhaphy. In operating upon the pelvic floor, the upper sutures are of catgut and the lower ones of silk, thereby obviating the necessity of removing the upper sutures, which embrace only the cut vaginal walls, and which are used only to help in narrowing the vagina. Silk is used in suturing the torn ends of the muscles and for the external sutures. The ones in the skin are removed in a week, those in the vagina after two weeks. He believes that it is wise to treat patients having procidentia for some weeks prior to their operation. The uterus should be reposited and kept in position by means of tampons.

In regard to the use of the pessary for procidentia he says: "Excepting those rare cases in which the procidentia has occurred in spite of the fact that the pelvic floor is intact, the use of the pessary for this condition is clearly illogical. A pessary can never restore a torn pelvic floor; and if this accident has been the cause of the procidentia, any treatment except the repairing of the injury is clearly illogical, and can be only of temporary value. The pessary is a useful instrument in the treatment of slight descensus and of retroflexion of the uterus when the pelvic floor is intact. The pessary should be supported from below, partly by the vagina itself and largely by the encircling slips of the levator muscle. It should never get its support from the pelvic bones, which is what happens when a large pessary is introduced to hold up a procidentia when the pelvic floor is widely torn. Used under these circumstances, a pessary must be large in order to be retained, and when it is large it invariably presses against the pubic bones. It is only necessary to point out how illogical this use of the pessary is in order that its application may be condemned."

Dr. J. T. Wilson discusses the question

**Does Gonorrhœa in the Female Invariably Prevent Conception?**

in a short but interesting paper. After reporting several cases in which the patient became pregnant atter undoubted infection he says:

"That gonorrhœa does frequently prevent conception is probably well established, but I do not think it is by any means a universal rule. Clinical illustrations are too many to the contrary.

If Nœgerrath's statements were literally true, sterile women and fruitless marriages would be far more common and the increase in the race would be greatly lessened, for these are a surprisingly large percentage of men, judging from my experience, who, if they confessed the truth, have suffered at some time in their lives with gonorrhœa."

Dr. Robert P. Harris contributes a description of "The First American Symphysiotomy," which he claims was performed by Dr. William Thomas Coggin, now of Athens, Georgia, who operated in Freedman, Northeast Alabama, on March 12, 1892, more than six months before Professor Charles Jewett, of Brooklyn. The operation was an entire success. The remaining paper in this issue is "Nephro-Lithiasis" by Dr. A. H. Cordier.

THE BROOKLYN MEDICAL JOURNAL

for March. Dr. James P. Warbasse writes on the

**Etiology of Carcinoma.**

The author does not believe in the bacterial origin of this disease, and giving the history of a number of theories of such origin, shows that the organisms found by their originators are also found in other growths, and so cannot be specific. Also, since other ptomaines give reactions in these growths, the author does not regard the poisonous watery extract "cancroin," of Adamkiewicz, as proving specific antagonism, as tuberculin does in tuberculosis.

The theory the author upholds is that for some unknown cause the epithelial cells of an organ undergo malignant change, and while still partaking of the peculiarities of form, function, etc., of the organ primarily affected, they migrate and form new malignant growths, the cells of which carry on a perverted function resembling that of the organ first diseased. In proof of this theory, the author quotes secondary post peritoneal nodules, the cells of which were similar to the cells of the liver, primarily affected, and states that the fluid exuding responded to the tests for bile; also metastatic growths in bone, presenting alveoli and colloid material, resembling the thyroid gland where the primary growth existed.

Dr. Frederic A. Cook (Surgeon to the Peary Arctic Expedition) describes

**Gynecology Among the Eskimos.**

He came in contact with a tribe of about two hundred and fifty persons, known as the Arctic Highlanders, living on the Northwestern Shore of Greenland. These are probably living farther north than any other human beings in this region, and are closely confined to the territory they occupy by the peculiar situation of the country. The temperature for nine months in the year is about 20° to 50° below zero. These people, the author states, live entirely on the flesh of animals and birds, and use no salt.

Girls are married at twelve or thirteen years of age, but do not menstruate until nineteen or twenty, and do not menstruate at all during the long arctic night, four months long in this region, and look forward to the return of sunlight and menstruation to cure any disease that may spring up at this time.

The average is three children in every family, and a woman who proves sterile may be cast off by her husband, and pass on to another, until finally the birth of a child becomes a bond of marriage. Very few, the author states, prove sterile.

When about to give birth to a child a woman is put in a stone house, or, if this be not obtainable, in a snow hut, or in summer in a skin tent, absolutely alone. She is given food enough to last two or three weeks, and she gives herself any attention she may. The cord is cut by grinding between pieces of stone, and is tied with sinews.

After the cries of the child have been heard by those outside for about a week the house is opened, and visits are received from female friends. The mother is considered unclean for some time, and men will not enter the house.

Death is a common result of this peculiar custom. Abortions are very rare, and the victim of one is an object of ridicule. Children are nursed by the mothers for five or six years. Diseases of children are few, and mortality among children is small. Measles is not a common disease, but is fatal when it appears. Rheumatism and consequent heart troubles are about all the adults suffer from.

A little farther south the unfortunate effects of civilization are seen; contact with missionaries has led to better care of mothers and children, but also to the use of civilized clothing, whiskey, coffee, tobacco, tea and sugar, all unsuited to Eskimo manners of life.

Two-thirds of these people are thought to be tuberculous, while not one case was known in the northern district, and Grippe, which was very trifling in the north, is very fatal in the southern region.

A profouse blood supply, the author says, leads to continuous bleeding from the most trifling abrasions, when white men in this region seem to have the blood driven from the surface by the cold. Another interesting pecularity is the presence of a layer of blubber beneath the skin in all parts of the body.

Pictures of animals, people, etc., shown these people were held upside down, and sketches of animals made by them were made in the same way; but those who had been among the missionaries had lost this habit. This coincides with the theory of the inverted retinal image being mentally reversed, as a result of education.

During an interesting discussion which followed, the author declared that of forty-one or forty-two women, he was able to find only two or three with thoracic respirations. Syphilis is unknown among those who have had no contact with white people, but universal among the others. Sexual intercourse seemed only to take place during the period of sunlight, as at the approach of night the people lost strength, and became chloro-anæmic, and the slightestexertion of any kind was fatigueing. This exhaustion in the absence of sunlight was felt by the exploring party also, and led to a condition of great depression.

Dr. T. S. Lawrence writes about iodide of lime as a specific in membranous croup. He distinguishes between light-colored iodide of calcium, which he had no success with, and dark iodide of lime, which he finds of great value. Ten grains of the drug are dissolved in four ounces of water, and one or two teaspoonfull given every fifteen, thirty or sixty minutes, until the cough becomes moist. He mentions quebracho as a drug that enables red-blood corpuscles to absorb more oxygen than the usual supply from a given volume of air. He used five-drop doses of the fluid extract every three hours for a child eighteen month old.

Dr. George Dederic Holston contributes an article describing

**Neurotic (Reflex) Eczema.**

The author says although this disease is unquestionably eczema (a catarrhal inflammation of the skin) yet it differs from ordinary eczema in clinical appearance, etiology and treatment.

It occurs at all ages, but is most frequent under two years of age. Location, symmetry, tendency to sudden remission or aggravation, and rebelliousness to external treatment distinguish this from ordinary eczema.

In children the most frequent sites are the face or scalp, in whole or part, the upper extremities, confined to the extensor surfaces, deltoid, etc. Individual patches are sharply defined, circular, elliptical, or ovoid; and while resembling zoster, they group at the termination or decussation of nerves, instead of along their course.

All the appearances of ordinary eczema are seen, and the patches usually show vesicles. It differs from ordinary eczema in affecting the cheeks and extremities symmetrically.

Cases are cited to show the effect of hygiene, regulation of diet, bowels, etc., also the relief of adherent prepuce, or any kind of genital irritation, and the uselessness of local treatment without this.

Nervous sedatives may be required, in some cases ergot is very useful, and often the itching is so great as to call for salicylic acid, and menthol, ichthyol, carbolic acid, etc. Counter irritation to the neck or over the spine sometimes gives a marvelously sudden remission.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Acute Tonsillitis.

Dr. C. Edwin Miles says, in the Massachusetts *Medical Journal:* "If the pultaceous deposits develop on the tonsils or fauces, I find no remedy to surpass the following:—

℞ Ol. eucalyptus glob. ..... mxv
Spt. camphor ..... ʒiss
Tinct. guaiac. ..... ʒiiiss
Glycerin ..... q. s. ad ʒj

M. Sig.: Put 20 drops on a bit of sugar and allow it to dissolve in the mouth, every hour or two."

### Irrigation of the Stomach in the Treatment of Obstinate Hiccough.

Dr. Gallant in *Med. Week.* The author describes a case of presistent hiccough in which this unpleasant symptom occured at intervals of one or two minutes and lasted for three days. During sleep no singultus occurred. Temporary relief was obtained by the administration of the hydrochlorate of cocaine gr. 1-10 every 3 hours, followed later by 1-12 gr. doses of hydrodchlorate of pilocarpine three times daily. The hiccough reappeared and was more pronounced. Suspecting it to be of gastric origin Dr. Gallant washed out the stomach; immediate relief was afforded and the spasm promptly disappeared. A second case of obstinate hiccough which resisted chloral, opiates, ether and bromides responded to catheterization of the bladder which was distended and relief temporarily obtained for about 8 hours. Lavage of the stomach caused an entire cessation of hiccough in this case also. Gastric irrigation being a simple and harmless procedure, it ought to be resorted to in every case of obstinate hiccough whether of gastric origin or due to nervous irritation. In nervous hiccough favorable effects ought to be produced by diminishing the reflex irritability of the nervous system as was shown by passing a catheter in the case above described.

### Ice in Acute Pneumonia.

Prof. Mays urges the value of this treatment. He has the chest on the front side and back of the area affected surrounded with rubber bags filled with ice. The number of these depends on the size of the area involved. They are allowed to remain until the temperature becomes nearly normal. If a new portion of the lung is involved, the ice bags are removed to this spot, and this is continued until the tendency to extension ceases. —*Philadelphia Polyclinic.*

### Antipyrin as a Hemostatic and a Antigalactagogue.

Dr. J. S. Davis depends on antipyrin as a local hemostatic. Its effects are prompt and lasting. There is no clot to interfere with primary union, and it is in every respect the ideal hemostatic. When possible the powder is sprinkled over the bleeding surfaces and covered with borated gauze. When this method cannot be pursued a fifty per-cent. solution is injected.

By giving it in doses of four grains, every two hours, the lacteal secretion will be suppressed in from two to six days without any change of diet. He has never found it necers sary to continue the treatment longer than four days.—*Medical Review.*

### Treatment of Intestinal Hemorrhage in Enteric Fever.

James W. Allen, M. B., says: The first indication is stillness on the part of the patient. Soda water and milk, sherry whey and (if the patient is very weak) a little brandy and water—all iced—may be given at reasonable intervals. Of course free stimulation is out of the question. The patient may be permitted to suck or swallow small pieces of ice. Large draughts of fluid should be

avoided. If the hemorrhage is considerable in amount the external application of cold to the abdomen is one of the first remedies which ought to be employed. This should be done with a Zeiters' apparatus, or similar arrangement, and not with heavy and leaky bags. It is better to employ the external application of cold in an intermittent than a constant manner, for example use it an hour and omit it an hour. In addition to above methods of application of cold it may sometimes be advisable to introduce pieces of ice into the rectum.

In regard to the use of drugs the author speaks of three which he has used. These are: 1. Lead and opium combined in pill; (2) Turpentine; (3) Liquid extract of ergot named in the order of their merit.

### A Word for the Sleepless.

Dr. J. E. Huxley of Maidstone, Eng., thinks he has hit upon the natural remedy for sleeplessness. It is in brief to curl under the clothes like a kitten or put the head under the wings like a hen. His detailed description of the technique is given in a letter to the *Medical Press and Circular*, when he says: This insomnia seems now to be a universal affliction. We live wrongly; sit up late and overwork the brain and thus go to bed in an excited condition. No one seems to have hit upon the natural remedy. I think I have. People take chloral and the like at their peril, and a fatal consequence not seldom ensues. It is all wrong, for you cannot control the dose required for the exact circumstances. But try natures plan instead—lower the supply of oxygen to the blood, produce a little asphyxia, limit the quantity of air to the lungs, and the heart and circulation becoming quicker, the brain loses its stimulant and sleep follows. When you find yourself in for a sleepless night, cover your head with the bedclothes and breathe and rebreathe only the respired air. Thus you may reduce the stimulating oxygen and fall asleep. There is no danger. When asleep you are sure to disturb the coverings and get as much fresh air as you require, or when once drowsiness has been produced, it is easy to go on sleeping though the air be fresh. What do the cat and dog do when they prepare to sleep? They turn round (generally three times) and lastly bury their noses in some soft hollow in their hair or fur and "off" they go. They are in no danger, although it might look as if they were from the closeness with which they imbed their noses.—*Med. Rec.*

### Calomel as an Antipyrtic.

Drs. R. J. Nunn and A. B. Simmons, of Savannah, Ga., in the paper prepared for the Section of Therapeutics (First Pan-American Medical Congress) remark: From the use of calomel in twenty-five cases of typhoid and continued fever cases we have drawn the following conclusions:

1. Calomel is a sure and safe antipyretic, reducing the temperature from two to three degrees in a few hours.
2. Small doses will prove of no avail.
3. The ingestion of large doses was followed by no untoward event, no ptyalism, no hyper-catharsis. This is contrary to the usual opinion.
4. Diarrhœa, hæmorrhage, albuminuria, tympanites have not been contra-indications to the use of the remedy.
5. The reduction of temperature occurs without cathartic action on the bowels.
6. The Calomel acts best in combination with soda, bismuth and pepsin.
7. In some instances, the remedy appeared to cut short an attack, and in others, while having no influence on its duration, it modified all symptoms, and by keeping temperature in check, aided materially in the management of the case.—*Journal American Medical Association.*

### Prevention of Boils.

Dr. Roensbach (*Munch. Med. Wochenschr.*) in order to prevent the development of crops of boils, in the back of tbe neck and nose, especially advises persistently rubbing the region attacked with some fatty substance, as cold cream, lanoline, unsalted butter or lard. Lanoline, above all is to be preferred. The development of boils is due to dryness of the skin, and by inunction of a fatty substance the dryness is removed and the penetration of micro-organisms prevented.—*Ex.*

### Chronic Bronchitis, Etc.

The following is a formula of the late Dr. William Thompson, who died several years ago, at Lazaretto, Philadelphia, of yellow fever:

℞ Fl. ext. tarax.....
Fl. ext. rhei.....
Syr. senega.....
Tinct. tolution.....ää ʒ ss.
Sod. bicarbonat.....ʒ j.

M. Dr. Thompson prescribed this for a patient who had chronic bronchitis, acid dyspepsia, etc, with good effect, in doses of one teaspoonful three or four times daily

REFRIGERANT, SEDATIVE AND EXPECTORANT.

℞ Cit. potass. liq.....ʒ iij.
Spir. nit. dulc.....ʒ iiij.
Tinct. lobelia.....ʒ ij,
Oxy. scilla.....ʒ v.
Syr. simp .....ʒ ij

M. Sig. Teaspoonfnl pro ren ata.

The above was prescribed by the late Dr. Condie. A very efficient remedy, rather in advance of its time.—*Buckley Medical Summary.*

### A New Treatment for Pertussis.

Sidney B. Straley reports the results of the use of thymus serpyllum in pertussis. He used a tincture made from the green drug. His conclusions are:

1. Thymus serpyllum is a specific for pertussis.

2. It acts in any stage of the disease.
3. It also is a nerve sedative and gastric stimulant.
4. It is necessary to use the green plant.
5. It is perfectly harmless in doses as large as a teaspoonful of the tincture for a child of eight years.
6. The action is fully established in twenty-four hours and completed in five days.
7. Lastly: indications are that there will be no recurrence subsequently, at least not more often than in cases which run the full course.—*American Doctor.*

### Tuberculosis.

℞ Iodoformi..... gr. 20-40
Ess. eucalypti... .....
Ess. terebinthinae ... ..... ....
Ess. guaiaci.....
Creasoti..... .....āā fl 3j

M. Sig. By inhalation or spray of from five drops upward.

—*Ex*

### Importance Attached to the Condition of the Tonsil.

The author calls attention to the prominence given the tonsils by the act of gagging, which forces them forward and toward the median line, cutting off the view of all that lies beyond. Moreover, the difficulty of posterior rhinoscopy and the mystery surrounding the function of the tonsil all unite to direct the physician's attention to these little bodies. The examination of the tonsils should be conducted while they are in repose, so that any changes in the adjoining tissues may be recognized and properly treated. The author shows that the symptoms usually ascribed to large tonsils may likewise be due to the other causes (adenoid disease, etc.), and he would have these eliminated before resorting to tonsillotomy.

In conclusion, he presents the following summary:

1. Because the tonsils are easier to see than the nose and post-nasal space, is no sign that they are more important than the latter.
2. Form no estimate of the size of the tonsil unless you see them in repose.
3. Always examine the back teeth and the base of the tongue.
4. In acute follicular disease of the tonsils, look for and treat disease of the other follicular tissues in the throat.
5. Nasal obstruction, cough, and impaired voice are much more likely to be due to nasal or post-nasal hypertrophy than to tonsillar hypertrophy.
6. The fact that the tonsils are enlarged or diseased should lead us to look for a possible explanation in the parts higher up.
7. Free the nose and post-nasal space in addition to, or instead of, tonsillotomy, if you wish to improve the voice and respiration.

### Jaundice.

In jaundice, due to exposure to cold, which has brought on a slight hepatic congestion, Prof. Hare says that in a large number of cases colomel given in $\frac{1}{6}$ of a grain doses until $\frac{1}{2}$ of a grain has been taken will be found to give relief.—*C. and C. Rec.*

### Cardiac Tonic.

Dr. Edward C. Mann, of Brooklyn, N. Y., in the *Physician and Surgeon* gives the following formula:

℞ Caffein. hydrochlor.,..... 3 iss.
Strychniæ sulph.,..... ..... gr j.
Ext. belladonnæ,..... gr. iss.
Fel bovis insp.,..... 3 j.
Ext. colocynth. comp.,
Ext. aloes, ..... aa gr. xxx.
Ext. taraxaci,..... gr. 45.

M. et fiant pil. No. xxx. Sig. One three times a day.

—*The Medical Bulletin.*

### Intestinal Fluxes.

Dr. J. Zach. Taylor advises:

℞ Pulv. opii,
Pulv. plumb. acetat.,
Camphor-gum..... aa gr. xxx.
Ext. capsicum fl ,..... ..... gtt. x.
Beech-wood creasote,..... gtt. v.
Alcohol, q. s. to dissolve camphor.

M. ft. pil. No. xxx.
Sig. One to six pills daily, according to urgency of case.

—*St. Louis Courier of Medicine.*

### Removal of Warts.

For the removal of warts, Dr. R. B. Morrison, of Baltimore, Md., prescribes the following:

℞ Hydrarg. bichlor.,... ..... ...gr. v.
Acid. salicyl.,.....3j.
Collodion, ..... .....3j.

He sometimes increases the bichloride of mercury to thirty grains in the same quantity of collodion, if the milder application does not answer. It is applied every day once, the upper crust of the previous application being removed before a fresh one is made. Four such applications generally softened the wart to such a degree that gentle friction removes it plainlessly, the further dressing being any simple ointment.—*Ex.*

### Tubercular Cystitis.

℞ Ext. belladonn ,
Ext. oppii,..... aa gr. $\frac{1}{6}$.
Iodoform,..... gr. $\frac{1}{4}$.
Ceræ,..... gr. xv.
Ol. theobrom.,..... gr. 45.

M. ft. suppos. No. j.

—*La. Medicine Moderne*

### Infantile Convulsions.

Infantile convulsions are treated by Dr. Jule Simon with the following:

℞ Chloral hydrat.,
Potass. bromid.,..... aa gr. xv.
Syr. codein,..... gtt. x.
Tinct. moschi,
Tinct. aconiti rad.,..... aa gtt. x.
Aq. aurant. flor ,..... ad 3ij.

M. Sig. Teaspoonful doses, or by enema if it cannot be taken by the mouth.

—*El. Sigo. Medico.*

### Constitutional Syphilis.

A mixture often ordered in constitutional syphilis by Dr. Keyes is as follows.—(*Cincinnati Lancet-Clinic*):

℞ Potass. iodid.....3ij
Ammonii carbonatis.....3ss
Tinct. cinchonae comp.....3iv
Syr. aurantii cort.....3iss
Glycerini.....3j
M Sig. A teaspoonful, well diluted, after each meal.

—*The Coll. and Clin. Record.*

### Painful Pharyngitis.

℞ Sulphate of morphine.....gr. iv
Phenic acid.....
Tannid.....āā 3ss
Glycerine.....
Water.....āā 3iv
Paint the throat two or three times daily.

—*Eng. Med. Press.*

### Cardiac Palpitations in Neurasthenics.

Th. Zerner employs the following mixture:

℞ Iron pyrophosphate.....
Zinc bromide.....āā gr. 54
Digitalin tincture.....fl 3ss
Ergotin.....3iij
Orange flower-syr.....fl 3vj
Dist. water.....fl 3iiij½
One to three teaspoonfuls daily.

—*Amer. Med. and Surg. Bulletin.*

### Myalgia

℞ Liniment chloroformi.....
Liniment aconiti.....āā fl 3iv
Tinct. opii.....fl 3iij
Liniment saponis.....ad. fl 3iv
M. Ft. liniment. Sig. To be well rubbed into the painful parts.

—*The Practitioner.*

### Irritable Cough.

℞ Acidi hydrocyanici diluti.....3iss
Morphinae acetatis.....gr. iss
Mucilaginis acaciae.....3j
Syrupi pruni Virginianae.....3iv
Aq., ad.....3vj
M. et fiat mistura. Sig. A teaspoonful to be sipped every four or six hours.

—*The Practitioner.*

WHY, OF COURSE.—*Stivitts*: "The German investigators are experts in bacillus hunting, aren't they?"

*Whiffett*: "Well, wouldn't you naturally expert a germ. man to cholera microbe?"

## SURGERY.

### New Operation for Prolapse of the Uterus

Freund (*Centralbatt fur Gyn.*) proposes simply to narrow the vagina to any desired extent by encircling it with a series of permanent sutures, which begin just below the utero-vaginal junction and are placed one after another down to the external orifice. Freund has used for the suture material, silver-wire, but Edebohls, who has tried the operation, and recommends it, (*Medical Record*) prefers to employ silkworm-gut.

### A New Treatment of Naso-Pharyngeal Catarrh.

Bates (*Med. News*) has treated with benefit more than fifty patients by syringing the lachrymal sac and nasal duct. Of the remedies used, olive oil gave the most general satisfaction. The syringe used is the ordinary eye dropper, with a tube drawn out to a fine point, bent at an angle of 60°, and about one-quarter of an inch long. It is small enough to enter the smallest punctum, and tapers so abruptly that it closes the largest punctum, preventing a return flow of the fluid.

To make the injection, the operator sits in front of the patient. Artificial light from an argand burner is reflected by the forehead-mirror on the inner side of the eye, direct illumination being less satisfactory. The operator may also stand behind the patient, who is then directed to look upward and outward. A piece of cotton about one-fourth of an inch in diameter is placed over the semilunar fold and held with the forefinger of the left hand with slight pressure against the upper punctum; this prevents the fluid from entering the eye from the punctum of the upper lid. The thumb of the left hand everts the lower lid sufficiently to expose the punctum.

The syringe, partly filled with the fluid to be injected, is lightly held by the bulb with the thumb and first two fingers of the right hand, the tip is inserted into the punctum and the syringe turned until the tip is at right angles to the margin of the lid and parallel to the conjunctival surface of the lower lid. Slight pressure is made on the bulb, and the level of the fluid in the syringe is seen to descend as the injection is being made.

Sometimes the injection is difficult, after the tip is introduced into the punctum; and, manipulation of the syringe up, down and in various directions, will be required to free the point from obstructing conjunctival fold. Nervous patients give trouble, and in such cocaine helps, but does not always relieve the difficulty.

### How to Cut Short Paroxysms of Whooping Cough and Some Neuralgias of the Trigeminal nerve.

Maegely (*Mercridi Med.*) Lift the hyoid bone and larynx by the thumbs applied under the greater cornua, the index fingers being kept on the ears and the other fingers on the neck. The duration of this procedure should be from a minute to a minute and a half. The author claims for his method certain cessation of the paroxysms of pertusses and relief in trigeminal neuralgia, hemicrania and globus hystericus. It is probably a phenomena of reflex inhibiation. Occasionally several attempts are required.

### Viburum for Treatment of Abortion.

Polak advises rest in bed. Morphine or opium per rectum and drachm doses of the fluid extract of viburum, or four-grain doses of the solid

extract in pills. Of thirty-two cases treated in this way, none resulted in miscarriage.—*New York Journal of Gynecology and Obstetrics.*

### The Treatment of Cholera.

By H. Rosahuksy, M. D. The following preparation has been used by me with great success in the beginning of cholera where there is profuse vomiting and diarrhœa. The same preparation has been highly recommended by Professor Botkin of Russia, and it is very extensively used by the Russian physicians. This preparation goes under the name of Guttae Botkina.

℞ Tr. Chinae Comp.
Anodyn Hoffmani.....ää 15.0
Acid Miur. Dil.,..... 2.5
Ol. Meuth Pip..... 0.3
Chinini Muriatici..... 2.0

M. S. Twenty drops three or four times a day during cholera.

In cholera infantum I use this preparation in divided doses and a large proportion according to the age, or in the following manner which gives excellent results.

℞ Acid Mur. Dil..... 2.0
Liquor Anod. Hoffman..... 6.0
Bismuthi Salicyl..... 6.0
Acid Carbol, (C. P.)..... 0.12
Glycerine..... 12.0
Aq. Meuthae Pip..... ad. 60.0

M. S. Teaspoonful every hour, according to age.

For choleraic diarrhœa, the following preparation is also good:

℞ Tr. Opii.....4. 0
Essentiae menthae.....
Liq. anod. Hoffmani.....ää 8. 0

M. Sig. Twenty drops four or five times a day.

—*Medical Record.*

## ARMY AND NAVY.

U. S. ARMY FROM FEBRUARY 25, 1894, TO MARCH 24, 1894.

Leave of absence for twenty days, to take effect upon the adjournment of the Eleventh International Medical Congress to be held at Rome, Italy, March 29 to April 5, 1894, is granted to Colonel Bernard J. D. Irwin; Assistant Surgeon General.

A Board of medical officers to consist of Major Joseph K. Corson, Surgeon; Major Walter Reed, Surgeon; Captain Julian M. Cabell, Assistant Surgeon, is by direction of the Secretary of War appointed to meet at the call of the President thereof, at the Army Medical Museum Building, in this city for the examination of First Lieutenant Philip G. Wales, Assistant Surgeon, to determine his fitness for promotion.

Lieutenant Wales will report in person to the President of the Board at such time as he may designate.

By direction of the President, the retirement from active service on the 25th of February, 1894, by operation of law of Captain George T. Beall, Medical Storekeeper, under the provisions of the act of Congress, approved June 30, 1882, is announced.

The leave of absence granted Captain Reuben L. Robertson, Assisstant-Surgeon, United States Army is extended one month.

Major John Brooke, Surgeon United States Army, retired from active service, February 22, 1894.

First Lieutenant Ashton B. Heyl, Assistant Surgeon, retired from duty at Fort Nichvava, Neb., ordered to Columbus Barracks, Ohio, for duty at that depot, on the arrival of Lieutenant Thomas S. Bratton, Assistant Surgeon, at Fort Niobvava, Neb.

## NEWS AND MISCELLANY.

### Acting Assistant Surgeons.

In the house of representatives, February 16, 1894, Mr. Richards introduced a bill to remove certain disabilities of the late acting assistant surgeons.

WHEREAS before, during, and since the war of eighteen hundred and sixty-one to eighteen hundred and sixty-five, but chiefly during the war, private physicians were employed as medical officers serving under the orders of their superior officers, as such, agreeably to Army regulations, in the armies of the United States, in addition to the commissioned medical staff, because the number of the latter was not sufficient for the necessities of the service. This class of officers was known officially as acting assistant surgeons, because they performed exactly the same duties, and were subject to the same control as commissioned medical officers. These acting assistant surgeons were employed under contract made in accordance with paragraph twelve hundred and sixty-eight, Revised Regulations of the United States Army, eighteen hundred and sixty-one, and paragraphs thirteen hundred and four and seventy-one, Appendix B, Revised Regulations, eighteen hundred and sixty-three, and were obliged to remain in the service of the United States for a stated time. Among these officers were many of the eminent physicians and surgeons of the United States. Some of the duties performed by acting assistant surgeons were as follows: They were in charge and command of United States military hospitals, known as general, division, field, and post hospitals: they had charge and command of United States military hospitals for the care of contagious disease; they were in command or in charge of hospital trains, hospital boats, and ambulance trains, and were excecutive officers of United States general hospitals; they acted as brigade and regimental surgeons and at least one acting assistant surgeon acted as medical director of a department for nearly a year; they were responsible for hospital funds and property, and also post funds; they served on court-martial, which the Articles of War require shall be composed of officers, and also on

boards of surveying, in camp, field, and garrison, on overland expeditions, and in Indian wars; they faced death and endured hardships like commissioned officers, and it is known that nearly one hundred and fifty died in the military service of the United States; and

WHEREAS these acting assistant surgeons were allowed fuel, rations, quarters, and transportation in kind, and to purchase rations from the commissary, and traveling expenses the same as commissioned medical officers with rank of first lieutenant and were accorded, by order of the War Department, the same protection in their position, the same respectful subordinate conduct, and the same military courtesy from enlisted men as if they were comissioned officers, because they were placed in the position of comissioned officers so far as related to their duties. Many of them were also required to wear the uniform of an assistant surgeon. Acting assistant surgeons who were disabled by reason of disease contracted or injury received in the military service have been granted pensions under a law which assimilates them to the rank of first lieutenant of the military or Marine Corps; and

WHEREAS because they were not commissioned as officers, but were employed by contract as such, they are denied admission to military organizations like the Loyal Legion and the Grand Army of the Republic; and to relieve this unjust discrimination, and to give a proper recognition to their patriotism, duties, responsibilities, services, hardships, and exposures, they ought to be entitled to receive the rank for which they are allowed pensions and which will relieve them from these disadvantages. The appended bill is offered for this purpose. It involves no expense to the United States Government and no change in the relative rank of officers of the medical corps of the United States Army who have been or are now in the service of the United States; Therefore,

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That private physicians who were employed as medical officers in the armies of the United States for a period of not less than three months, in accordance with paragraph twelve hundred and sixty-eight of the Revised Regulations, United States Army, eighteen hundred and sixty-one, and paragraphs thirteen hundred and four and seventy-one, Appendix B, Revised Regulations, eighteen hundred and sixty-three, and who were known officially as acting assistant surgeons of the United States Army, and whose services were honorably terminated, shall be commissioned by the President of the United States as acting assistant surgeons of the United States Army; and the date of employment as acting assistant surgeons to be the date of commission and muster into service, and the date of the honorable termination of service as acting assistant surgeons to be the date of discharge or muster out of service: *Provided*, That no pay or allowance shall be made to any such acting assistant surgeon by virtue of this act; and this act shall not affect the rank, pay, or emoluments of commissioned medical officers of the United States Army.

### Cigarette Smoking.

We are glad to see a campaign inaugurated against the cigarette smoking curse; and we are pleased that the daily press is lending its assistance in educating parents to the evil of this terrible habit. It is also gratifying to find that so many clergymen, physicians and school teachers are doing good work in depicting the moral depravity and the physical degradation, that are sure to overtake the youngster who contracts and persists in the habit of cigarette smoking. We beg leave, however, to remind these workers in the good causes who are so ably and eloquently denouncing this most injurious habit, that no preacher is so eloquent and effective as he who practices what he preaches. Let the man with a cigar in his mouth (and several more in his pocket) explain to the small boy the evil consequences of smoking cigarettes, and he is likely to be met with the query—"What are you giv'n us;" the urchin cannot understand that a small cigarette can hurt a small boy if a large cigar does not hurt a large man. "Consistency thou art a jewel." "If eating meat causes my brother to offend, I will eat no meat."—*Ex.*

### The Old Story.

A correspondent of an English contemporary, writing from a small manufacturing town, says that the number of practitioners has risen there within four years from four to eight. The population in the meantime had not increased. As an evidence of how the doctors were prospering, three children of one of them were working in the factory. —*Ex.*

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### PSYCHICAL EPILEPSY.

S. J. FORT, M. D., Ellicott City, Md.

The curious relationship of the convulsive disease, the faint boundary lines between what may be termed a well-marked disease and another equally as well marked; the combination of two disordered conditions in the one person; the peculiar features of Jacksonian epilepsy; *petit mal* in one patient, *haut mal* in another, and both forms in another; irregularities of symptomatology occuring among groups of accurately diagnosed forms of disease; all such eccentricities of diseased action render this group of diseases extremely interesting to the physiologist, the pathologist, and the medical man proper, as well as to the medico-legal functionary.

The etiology in so many cases is obscure. The lesions, if any, would seem to be of a nature to produce contrary symptoms. Very frequently the scalpel and the microscope fail to find sufficient pathological results. Causes operating from without produce directly opposite results in individuals apparently of the same physical equality.

A blow upon the knee of one child produces no injury beyond the subsequent bruise, in another child a destructive inflammation is lighted up and the joint is wrecked. One child falls and strikes its head, traumatic epilepsy ensues; others endure the same injury with no permanent injury resulting. A bruise in one woman's breast produces a cancerous growth on the site of the injury; other women recover from deep-seated trouble in these glands without an after-result.

One child is delivered by forceps and lives to be an idiot; hundreds of others show no signs of such manipulation at the time of their birth.

Notable examples of pre-natal impression and accidents are found among the institutions devoted to the care of the feeble minded; among the many thousands who are annually born into the world, how many there may be who have been subjected to the most severe pre-natal shocks without injury, either mental or physical?

We study the tabulated family histories of our defective charges and gravely point out the terrible ruin of mind made by alcoholism in one or both parents; a similar study of family histories of thousands of parents addicted to alcoholism would show thousands of children born with minds to all intents and purposes sound and whole.

It may be that nature works without design in these troubles, that eccentricity of action argues a departure from rule in the primary cause of disease, but it is probable that the increased knowledge and further improved methods of study and research will eventually show the physical deficiency, if that be the reason; however infinitesimal it may be, it cannot forever elude the researches of modern science.

Of interest to the political economist as well as the medical man is the close relationship of the convulsive habit to crime and criminals, especially interesting since the latest crop of perverts, whose mental and moral obliquity turn towards the destruction of human life. That this relationship exists is without doubt within the bounds of possibility. A somewhat intimate acquaintance with mental defectives has caused me to think that there is a far more intimate connection between the habitually vicious and depraved and the epileptic condition than at present insisted upon by authorities in this specialty.

The late Dr. Kerlin, whose thirty years of intelligent study of imbecility renders his writings of great value, in a paper published in 1881, describes what he terms the epileptic change in feeble-minded children, and the following case is one he presents which will sufficiently illustrate the remainder of his valuable paper:

"A girl of four, when brought under observation, had a chronic habit of biting, but no other special eccentricity. During the fourteen years of training at Elwyn, she ranked high in her school duties and became useful in household duties, but never really gave up her habit of biting; her paroxysms were always unannounced by visible prodroma; they were directed against the loved and unloved, and she was as irresponsible and helpless when snapping at her victim as the typical epileptic when he falls to the ground; her face became flushed after the act, with a wild, lost look in it, or sometimes it was as the face of a swimmer rising from the water more chilly than was anticipated when plunging into it—cold, cramped and surprised.

There were long suspensions of these attacks, like the hopeful rests of epilepsy, to be followed, like them, with disappointment in a fresh outbreak of her irresponsible ferocities."

It would seem that the above case was that of what is now known as "psychical epilepsy," or the "psychical epileptic equivalent." Dana, one of the latest writers, thus describes psychical epilepsy, a sub-division of *petit mal*, or, to more accurately place it in its proper category, a sub-symptom of the mild form.

"Sometimes," says this author, "the minor attacks are followed by outbursts of maniacal excitement or by sudden, violent automatic movements, and in these cases, the patient commits crimes of violence. This form of epilepsy may come on without a preliminary minor attack, and then it is to be considered a psychical epileptic equivalent."

As I have said, I think that such a case as Kerlin describes would fall rather under this type of epilepsy, evidently identical with the "masked epilepsy" of Esquirol, the *epilepsia larvata* of Morel, rather than to be given as the prodroma of true epilepsy proper, and I place the two following cases of my own in the same class.

The first is a girl now eighteen years of age, who came under my care five years ago. She was then a dull, stupid imbecile, utterly unused to the requirements of polite society, irresponsible to either love or fear, but with no especial history of outbreaks of violence or destructive habits. Under the softening influence of our school training, she gradually brightened, began to talk, learned to read and write, and displayed much affection towards her teacher and attendant.

One day she suddenly attacked her attendant, giving as an excuse that the attendant struck her first. When I saw her shortly after the fracas, she was a picture of sullen imbecility. Simultaneously with the explosion of muscular and nervous action, she seemed to have relapsed into the mental state of a year previous. In a week's time she was herself again, and remained so for a month or two, when she again exploded. Isolated for a time from her companions, she regained her equilibrium and was removed from our care to her house.

As soon as she got home, she had recurring fits of passion, alternating with periods of sexual excitement, finally going to bed and refusing to get up. By use of much physical force she was brought back to us, and the morning after her arrival she arose with the other patients, but seemed in a trance, refusing to talk, eating voraciously, leading an oyster-like existence.

Under active treatment, she finally regained her lost ground, but with her increased mentality came again the violent outbreaks of temper, followed by periods of depression. At no time in her history has there been any actual epileptic "fit."

Her family history is very bad. Her father is nothing more mentally, than a high-grade imbecile; her mother was an illiterate, excitable person, with an overgrown faculty for making money, who died recently of apoplexy, superinduced by overeating.

The other case is a boy nearly twenty. He had been under observation for three years. A nice, polite, clean fellow, capable of a certain amount of school education, fond of play, obliging and friendly. There was nothing in his history out of the ordinary run of congenital imbeciles. Both parents highly educated, and so far as known, no evidence of mental trouble anywhere on either side. The father lost a foot in battle, and has suffered intense neuralgia from the stump, the acme of

pain storms seeming to have been about the time the boy's mother became pregnant; this was the only symptom of nerve trouble anywhere in the history.

The boy showed signs of "backwardness" at an early age, and when about fourteen, without warning, eloped from home; he was returned by the police to a family well-nigh distracted, and further alarmed by his apparently being insensible. He recovered in a short time, and within two months ran away again; this time he was found unconscious under a tree in a park near the house. Coming to me, he became one of my most interesting cases, eagar to learn, easily controlled, and apparently trustworthy, giving no signs of any desire to elope for some time.

Looking out of a back window one afternoon during a heavy shower, to my surprise I saw this boy scudding across the field toward the woods. Immediate pursuit enabled us to corner him before he had gone very far, and he was finally located by a sort of barking noise, and evidences were plain that he had vomited freely. Brought home he was apparently unconscious, but when threatened with a douche of cold water rallied, and beyond considerable depression, was himself again.

Later on, he again ran away, this time not being captured until late in the evening; he was thoroughly exhausted by his efforts at pedestrianism, and kept his bed for a week.

That was the last time he ever essayed that eccentricity; later he developed a new phase. He was brought to me suffering from a pain he could not locate, and being sent to bed, remained there two days refusing to speak or eat. On the morning of the third day he got up with the other boys in his domitory, dressed and took his place in his class as though he had never been away.

Gradually we noticed that he was standing still mentally, the slightest rebuff or reproof or obstacle to his desires brought on a paroxysm of this alleged and exceedingly elusive pain, to be followed by a period of depression, refusal of food, and a most singular and marked physical change. He would begin the outbreak a fairly well-nourished boy, and in the course of a few hours would look as though he had passed through a serious illness; his cheeks and eyes sunken, his features drawn, respiration, temperature and pulse below the normal. Equally remarkable is the rapid recovery of lost ground when reaction once sets in.

The female is essentially vicious, and the boy needs only suggestion to become so; the moral sense is lacking in both, and it is only the force of example and environment that prevents either from joining the ranks of juvenile criminals.

It may be wrong to argue that a possible inherent tendency to spasms may produce a crime as a result rather than a fit, or that the relationship is so close that the criminal has a fit at one time, and at another the crime is substituted for the nervous explosion. "Human character," says Wood, "is the result of the established balance between the will and the intellectual attributes and the emotional forces of the individual. When any of the correlated factors are altered, there must be a corresponding change in character."

Close association with epileptics shows with great distinctness the result of this disturbance of correlated factors. The loss of will, the loss of memory, the lack of ability to inhibit the lower intellectual and emotional brain functions, the development of the passions, the growth of a superficial veneer of good behavior over the thoughts and desires of a satyr or bacchanal kept in suppression only by the fear of a superior strength, the brutal selfish, malevolent, surly, irascible, perverse egotism of epileptics is well known, especially in epileptic imbeciles. The Mr. Hyde of human nature is always in the ascendency, and we find these same characteristics in numbers of criminals, particularly in the younger male and females, who throng our courts and fill our station houses.

We have found out that the juvenile insane show a marked criminal tendency; we know that there is a distinct type of imbecile with the same tendency, which we call the moral imbecile, and I fancy, when each state will assume the burden of care and restraint of her epileptic defectives, that intelligent study will show that this terrible disease drives many of its victims to the penitentiaries, even to the gallows, for hideous crimes against the person, murder, arson, et al.

Proper education of the more juvenile delinquents would probably detect signs of what we have termed pyschical epilepsy, and proper treatment eradicate the symptoms or point out the propriety of life restraint.

# COMMUNICATIONS.

## FLAT-FOOT AND ITS TREATMENT; THREE RECENT CASES OF STONE IN THE BLADDER; LITHOLAPAXY.*

THOMAS G. MORTON, M. D., PHILADELPHIA.

Mr. Chas. S., of Richmond, Va., has suffered from various accidental injuries of the right leg and foot, the first was about fifteen years ago, which was a sprain of the knee from a fall in dancing; after which for many years he suffered considerable lameness; subsequently he twisted or sprained the ankle, and on several occasions this was repeated. A year ago he again injured the ankle, a probable sprain, and until July following was hardly able to walk, always requiring some sort of support; at that time he had a steel sole placed in the shoe, from which he had little if any relief; he then began to have spinal pain and a distressing aching in the neck and back of the head; could not go about except with the aid of a cane, suffered from exhaustion, became insomnious, lost appetite and weight.

On examination, early in January, 1894, I found a weak ankle and extreme talipes valgus. In addition there was asymmetry of lower extremities; the right or weak limb was three-quarters of an inch shorter than the other, and calf measurement showed the right half an inch less in circumference.

A lateral support was applied to the limb to support the weak ankle, and in the shoe, a Gefvert steel-spring arch; the short limb was made equal to the left by adding sufficient to the heel of the right shoe.

Mr. S. reports: "I can hardly realize that after so many years of suffering, and in so short a time, I would be able to walk again without pain. I find the steel spring comfortable, and I find no inconvenience in having it in my shoe; my back and head have been relieved, I presume, by the high heel."

REMARKS.—Either in uterine or early child life the patient had a slight one-sided paralysis which, although arrested early, was sufficient to interfere for a time with the growth of the extremity, and this accounts for not only the ankle weakness, but the variation in the length and size of the right as compared with the left limb. Valgus—indeed, all the varied forms of congenital talipes arise in the same way. Spinal and head pain is frequently associated with and caused by a short limb; the constant shocks the spinal cord and brain are subjected to in certain individuals is quite sufficient to bring about in nervous temperaments, perhaps with impairment of general health, just such a condition.

The weak ankle has in this case been marvellously improved. even in a comparatively short time, by the steel arch.

The spring arch, which I exhibit, is fastened in the shoe directly under the tarsal arch; it is made of two elliptical pieces of steel which are three and a half inches long and two inches wide; one plate is flat, the other is arched on its inner side, which is intended to support the tarsal arch; tne plates are joined together at their outer edge by a stout hinge, and the upper or arched plate on its inner side comes in contact with a lump of rubber which, when pressure is made from above, yields and gives the spring to the foot.

CASE I.—Leon F., aged sixty-six years, living in Kansas, a merchant, had never been sick until about twelve years ago, when he first suffered from bladder irritation, and, finally, with the most aggravated and distressing symptoms of stone in the bladder; subsequently he came to Philadelphia.

On examination, the urethra from the prostatic portion of the canal to several inches in advance was found distended by a series of calculi, impacted and joined together, forming, as it were, a long, continuous stone; the various facets, however, permitted more or less movement.

A median section over the most prominent stone exposed the urethra, and the calculi were readily removed; the stones distended the urethra to such an extent that when removed a finger was readily

*Read before the Phila. Acad. of Surg. February 5, 1894.

introduced into the bladder, in which three calculi were discovered and easily taken out without further use of the knife. Recovery and complete restoration of the function of the neck of the bladder followed.

Early in 1893, or about twelve years afterward, Mr. F. had a recurrence of irritation of the bladder, and later with the usual stone symptoms.

In May he came to this city and a calculus about an inch and a half was found, and on June 1st litholapaxy was performed and the bladder completely cleaned. Ten days later he was quite well and went West, and remained so until the latter part of November when, after slight renal pain, the symptoms of stone reappeared. A stone was found and removed by litholapaxy and without using an anæsthetic; weight, fourteen grains.

*January* 12, 1894. Having since the last operation been free of all bladder symptoms, he had two sharp chills and some fever, and almost at once irritation in the bladder followed; the sound detected a small stone, which was easily grasped by a small Luer crusher, and the stone was removed without breaking; weight, five grains.

25th. After another slight attack of pain and very slight irritation a small stone was seized and extracted; weight, three and a half grains; all symptoms have been relieved.

CASE II.—Col. T. H. R., aged fifty-nine years, came under my care November 11, 1893. Family history: grandfather and father had severe bladder trouble and supposed to have had stone. From a description of an attack through which a brother passed, it was supposed he suffered from renal calculus.

Present attack: about two years ago patient passed a stone for first time, since then stones of varying size have been passed; has had two attacks of renal colic.

In July, 1892, he was subjected to lithotripsy and received little if any benefit; his sufferings were in nowise lessened. In August last he was sounded and declared to be free of stone; his symptoms were judged to result from cystitis.

*November* 16. An examination of the bladder revealed a stone of considerable size; urine contained a large amount of albumin, but no casts.

18th. Litholapaxy was performed, the stone crushed and removed by Bigelow's apparatus.

*December* 9. Patient was free from vesical irritation and left for his home.

The calculus weighed 178 grains.

CASE III.—Mr. W. C. R., aged sixty-six years, consulted me at the request of Dr. J. A. Patterson, of Salem, N. J.

*History.* For twelve years suffered from attacks of rheumatism and sciatica, then for a short time had comparative health. Two years ago began to suffer from irritation of the bladder; the symptoms gradually increased in severity. The urine showed a large amount of pus.

*December* 12. Sounding revealed a large, hard stone.

21st. Litholapaxy and removal of fragments by Bigelow's evacuator; the stone weighed six drachms and fifteen grains, and was uric acid. Ten days subsequently the urine was normal, and all irritation having disappeared, he left for his home quite well.

REMARKS.—The ages of the three cases were respectively fifty-nine, sixty-two and sixty-seven years. Anæsthesia was omitted in one of the operations. In dilating the urethra a No. 31 bougie was used. The bladder was cleansed with boric acid solution and eight ounces of the same allowed to remain during the crushing. Prompt recovery followed in each case. In the first case the patient was free of irritation for nearly five months, then sudden irritation announced the descent of a renal stone; an entire absence of symptoms followed until a lapse of six weeks and two weeks' intervals, when small renal calculi entered the bladder and were promptly removed, using the small duck-bill lithotrite. Piperazine was given to each patient, and directions to have the bladder examined at intervals of four months.

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DR. PAUL GARNIER, of Paris, has made a special study of those slum children that are the offspring of habitual drunkards. He says: "There is a flaw in the very nature of these young wretches that the psychologist sees clearly and notes with apprehension — the absence of affectionate emotions, and where they did not become lunatics they show 'insensibility and pitilessness.'"

# LIGATION OF THE COMMON AND EXTERNAL CAROTID ARTERIES AND THE JUGULAR VEIN.*

W. W. KEEN, M. D., PHILADELPHIA.

Mr. St. John, a Frenchman, about twenty-five years of age; was first seen at the Presbyterian Hospital in Chicago, August 9, 1893, in consultation with Drs. D. W. Graham and N. Senn. Unfortunately, in consequence of change of residents and absence from the city, the history is imperfect.

About three years before I saw him he had been shot, the ball entering just below the tip of the left mastoid. He was unconscious for a brief time, but when he recovered, either the same day or the next morning, he discovered that his right eye was absolutely blind. In addition to this, his right arm was paralyzed, but whether immediately after the accident or at a somewhat later period was not ascertained. When I saw him, the right arm was the subject of contractures, the result of the old monoplegia. The leg and face was not affected. The aneurismal bruit and thrill were very marked, and could be felt down the left side of the head and neck. There was but little external swelling. The man sought relief on account of the noise produced by the aneurism, which made it impossible for him to do any work.

Operation, August 15, 1893, by the kind request of Dr. Graham. The carotid was laid bare by the usual incision over the anterior border of the sterno-cleido-mastoid, the middle of the incision corresponding to the upper border of the thyroid cartilage. Considerable difficulty was found, even at this stage, in consequence of the inflammatory adhesions resulting from the gunshot wound of three years before, and also from the fact that the vessels lay nearly under the middle of the sterno-cleido instead of under its anterior border. My intention had been, first, if the adhesions (the presence of which I had anticipated) would allow me to reach the internal carotid, that I should tie that and the jugular just above the bifurcation of the carotid; but if the adhesions prevented this, I determined to tie the common carotid and the external, the latter being tied so as to prevent the reestablishment of the current by the anastomotic circulation from the other side. Even the ligation of the external carotid above the bifurcation was quite difficult by reason of the adhesions. It was done just at a point were the first branch was given off, and the ligature was made to include both the external carotid and its branch in one loop. The jugular vien was tied at a point half an inch below the level of the ligature around the common carotid, in order that the necessary injury to the tissues should not be at the same level. The veins were very full, giving thus an additional evidence that the diagnosis of arterio-venous aneurism was correct.

Dr. Graham has kindly written me under date of October 2nd, as follows: "The wound healed practically by primary union. One angle was a little slow in closing, but there was no purulent discharge at any time. The morning after the operation ptosis and immobility of the left eye ball were discovered, although he could turn the globe outward somewhat, and slightly upward. The pupil was not affected, but responded to light. There were no mental disturbances or paralysis. In two or three weeks improvement began in the eye, and when he left the hospital three weeks ago he could keep the lid up nearly in a natural position, and could move the eyeball in every direction, promising complete restoration from the paralysis. He was to report to us occasionally, but I have failed to see him since then."

REMARKS.—I regret very much the imperfect history of the case, but the circumstances made it impossible to get any more complete history. For the same reason no examinations of the eye-grounds were made, either before or since the operation. Fortunately, the absence of a post-mortem prevents our ascertaining absolutely the pathology of the case. The ball after traversing the blood vessels entered the skull at its base, and without doubt cut the right optic nerve between the eyeball and the chiasm. The paralysis of the right arm was due, of course, to the involvement of the left motor cortex, or

* Read before the Phila. Academy of Surgery, February 5, 1894.

fibres proceeding from it. Whether the ball in entering the skull was split in two pieces, one of which injured the left cortex in the arm area, and the other the right optic nerve, or whether the paralysis of the arm was due to an embolus from the arterio-venous aneurism, can only be speculated on. None of the ball was ever found. What the final result as to the aneurism will be is not yet ascertained.

## SUGAR AS AN OXYTOCIC.

F. H. PRITCHARD, M. D., WEAVER'S CORNERS, OHIO.

Professor U. Mosso and Luigi Paoletti, at the conclusion of a mémoire on the Influence of Sugar on the Work of the Muscles, which mémoire was read before the Accademia dei Lincei (*Rendiconto R. Accademmia dei Lincei*, Vol. II, 2 Sem., Ser. 5, fas. 8), suggested "that we hope that it will be able to be used with advantage in therapeutics, to revive, for example, the pregnant uterus, tired out by effort, when expulsion of the fœtus is necessary." A distinct allusion is here made to the possible ecbolic action of sugar. In the *Gazzetta Degli Ospitali*, No. 2,1894, Prof. Bossi, of the Obstetrical and Gynecological Clinic of Genoa, Italy, reports the results which, since the publication of Professor Mosso's experiments, he has obtained with sugar as an oxytocic in a large number of cases. As it was known to have an effect upon the voluntary muscles it was thought probable that it would also act on the involuntary. In these experiences he sought to exclude all sources of possible error as to suggestion. As he was in charge of the Obstetric Guard of Genoa, he distributed to each member a number of powders of finely powdered sugar, each containing thirty grams (about an ounce) with directions to give one powder in cases of uterine inertia and, if requisite, to repeat the dose after two hours. As the members of the Guard are only called in by midwives when there is a relative or absolute uterine inertia, and where something is urgent, these results are worthy of notice. He concludes as follows:

1. In ten out of eleven cases a positive ecbolic result was obtained from an ounce of sugar in eight ounces of water. This effect was observed on an average a half hour after its administration.

2. In some cases the one powder was sufficient to induce expulsion of the fetus.

3. If a second powder were given after two hours, the effect was more pronounced.

4. In no cases were tetanic contractions observed, while on the contrary, the contractions were regular and no incarceration of the placenta was noted.

On account of these favorable results he reports them and thinks that he is justified in recommending the use of sugar as an ecbolic in obstetric practice. It is prompt in its action; is not associated with certain disadvantages as ergot and its preparations, it does not cause tetanic action, is not liable to be followed by incarceration of the placenta or the fetal parts as with ergot and, on account of there being no danger of poisoning, the dose may be increased and repeated without danger to either mother or fetus. It is easily found in any family and hence may be had at all times. It short, he states that it possesses all the advantages of an ideal ecbolic without any disadvantages.

The night next after reading this article I was called to see a healthy German woman in the country, who had already given birth to two children, who are now alive and well. It was then half-past three in the morning. The pains had begun at supper time the evening before, and reappeared at slightly regular intervals, but not with much intensity. On external palpation I found the child with the head presenting and on the left side. Internally I found everything to be normal and the head presenting in the left occipital position. The cervix was well dilated, but there was nearly no bag of waters, the head having forced itself down early and allowing none to escape in front into the cervical sac. The pains came on now and then, but they were not of much consequence from their weakness. I waited a half hour, and then I thought of the sugar and the Italian article. Without any faith

in the measure I took a tablespoonful of granulated sugar, dissolved it in a glass of water and gave the woman a swallow. There was a very slight increase in pains after about twenty minutes when I had her take two swallows of the solution. In twenty minutes more, the pains came on with great intensity. They absolutely gave her no rest, rolled on one after another, and in a short time, one half-hour after the last dose the child was shot out between her thighs. I was somewhat alarmed with the rapidity and intensity of the pains for I feared the consequences of a precipitate birth, but fortunately there was no permanent tear nor inversion, etc. The placenta followed in about two minutes, and there was no more hemorrhage than usual in such cases. After about half an hour she complained of griping pains which I treated by a warm compress and whiskey over the abdomen and went home thinking all would quiet down, in the course of a few hours. But it did not. The pain came on every few minutes all that day so as to be distressing, The next morning at one o'clock, I was called by her husband and told that she was having some "queer spells" that went beyond the comprehension of her mother, the attendant. I hastened down to the house and found that she was suffering from a sort of terrific after pains so severe at times as to cause the sweat to stand out on her face, while the uterus would contract as hard as a billiard ball. I took in the situation at once. The sugar had overdone its work, and given rise to tetanic contraction of the uterus. Hot compresses to the abdomen and paregoric internally relieved them somewhat, but it was only after drop doses of the tincture of gelsemium every hour that they calmed down. The day after that they had disappeared entirely, though the day of the morning when I was called they continued, but were not distressing nor severe.

From the literature and my single experience I conclude that sugar is an efficient oxytocic, and one which is devoid of danger in ordinary and carefully measured doses. Though Bossi states that it will not cause tetanic contractions, my one experience leads me to the contrary view. That employed in graduated and measured doses, at regular intervals, of say, two hours, it will give good service. That it does not increase the force of the heart-beat and other disagreeable symptoms, like quinine when used as an oxytocic; nor like ipecac, cause vomiting nor is it cumbersome and bothersome like the hot douche, but is handy, quite certain, and easily obtained everywhere. That large doses will cause tetanic contractions and induce painful after-pains. That gelsemium, in drop doses of the tincture, is antidotal to this over traction.

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**Pertinent Facts on Vaccine Virus.**

Keep in a glass-stopper jar in an unheated room in winter and in a refrigerator in summer.

Do not carry in an inside pocket.

Do not use too much water.

Do not abraid too large a surface.

Do not use any dressing.

Do not report until the 8th, or better, the 10th day.

Our plan of operating is as follows:

We scarify by scraping off the scarf-skin from a surface about one-fourth of an inch square over the insertion of the deltoid muscle, scratching the surface thus abraided in two directions.

We touch one side of the ivory point with a drop of water, immediately shaking the excess off; rub this side briskly on the abrasion and then form a paste by using the dry side of the point.

We finish the operation by gently scratching the virus in with the point we have used.

We are then certain of getting some of the vaccine corpuscles within reach of the mouths of the absorbents.

Too much water, with the serum that exudes from the arm, frequently washes away the corpuscles, while too thick a paste, if not pricked in, will dry as a varnish, beyond the reach of the absorbents which have been closed by the rubbing process.

If you protect with a shield, see that it is properly ventilated.

Failures result from

Using unhealthy or poorly fed cattle.

Pressure used in removing Lymph.

The clamor of physicians for colorless points.

Hot mail-cars, drug stores and physicians' offices.

Improper methods of operating.

Old goods, or mucilage and croton-oil points! sold at cut-rate prices, while human lives are sacrificed.

DR. H. M. ALEXANDER.

# TRANSLATIONS.*

## PHYSICAL DIAGNOSIS OF BILIARY CALCULI.

C. Gerhart calls attention to the early symptoms of biliary colic. The attack begins often four to five hours after a hearty meal, or when the food passes into the duodenum, causing, by a reflex action, an expulsion of bile from the gall bladder. This will produce a temporary sensible enlargement of the sac (supposing that obstruction of the duct exists, and the gall cyst retains its distensibility). This enlargement subsides as soon as the stone has passed; the localized inflammation having produced some peritonitis, a circumscribed area of crepitant rales can be heard with the aid of the stethoscope. This, together with pain, may exist some little time after the stone has found its way into the intestine. This latter condition is often greatly ameliorated by applications of ice water. An extension of the peritoneal inflammation to the pleura is but rarely observed. As a most frequent complication, we have an appendicitis due to a mechanical or chronic obstruction. If the attack is prolonged, the liver becomes enlarged and its edges can be easily palpated and often seen, if the patient is emaciated. Transient enlargement of the liver, one of the important symptoms, is also met with in cholelithiasis, or when the ductus communis is obstructed by ascaris lumbricoides, or other catarrhal inflammatory exudations. The head of the pancreas is also the seat of a new growth or swelling, thus producing mechanical pressure upon the duct; on the other hand it is absent in cardalgia or purely nervous hepatic colics.

Cholelithiasis can be excluded if there be an absence of crepitation over the seat of the gall cyst— if there is no enlargement of same, and if after several attacks there have been no calculi found in the fæces.—*Deut. Med. Wochen.*, No. 46, 1893.

—W.

## SACROMA AT THE BASE OF THE SKULL; SECONDARY AFFECTION OF THE TEMPORAL BONE.

Dr. Schwiedof (*Arch. f. Ohrenheilk*, xxxv pg. 39), reports a case of a young man, aet 30, who had suffered for some time of tinnitus aurium, deafness, occasional discharge of pus from both ears. Other symptoms were present which did not belong to mastoiditis; stiffness and pain in the cervical region, headache, dizziness, difficulty in deglutition. The use of Glisson's extension apparatus was of little or no benefit. A diagnosis of tubercular ostitis of the atlanto-occipital joint was made, and it was decided to chisel off the antrum mastoid, with the result of finding a glandular swelling about the size of a pigeon's egg, behind the sterno-cleido-mastoid muscles. There was an absence of empyema or pus beneath the periosteum.

The patient's strength decreased rapidly, other muscles became paralyzed, viz. glosso-pharyngeal, the hypo-glossus, and lastly the vagus became affected (decrease of pulse rate and respiration); this ended in death.

An autopsy revealed a tumor situated at the base of the skull, occupying a space $\frac{2}{3}$ toward the right and $\frac{1}{3}$ to the left of the median line. A careful examination of the petrous portion of the temporal bone could not be made. A histological examination of the tumor proved it to belong to the spindle-celled sarcoma. The early symptoms regarding the disturbances in hearing, are attributed by the author to the early mechanical occulsion of the Eustachian tube. This then becomes an all important symptom in the diagnosis of these diseases; in which opinion he is supported by Gerhardt and Moos. —W.

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

## THERAPEUTIC SUGGESTIONS FROM FOREIGN JOURNALS.*

### CREASOTE AND SULFONAL IN WHOOPING COUGH.

In the *Rivista Clinica e Terapeutica*, No. 12, 1893, the following formula is recommended in whooping cough:

℞ Creasote.....25 cgms (grs. iv)
Sulfonal..... 20 cgms (grs. iij)
Syr. tolu.....150 gms (℥v)

Teaspoonful every two hours.

### BORATED SALVES AS DRESSINGS.

Dr. Koehler (*Union Médicale*, No. 39, 1893), employs the following salves as surgical dressings:

℞ Boric acid.....10 gms (℥ijss)
Glycerine.....30 gms (℥j)

℞ Lanoline.....40 gms (℥jss)
Vaseline.....20 gms (℥v)

℞ Lanoline.....50 gms (℥jss)
Vaseline.....10 gms (℥ijss)

### ALKALINE NITRATES IN MALARIAL POISONING.

Dr. Buro (*Gazette des Hôpitaux*, No. 125, 1893) has employed the nitrates of soda and potash in malaria and claims that they are specifics having an action similar to that of quinine. In adults the dose is from one to one and a half grams (fifteen to twenty-two grains) per diem. They may be given either during the intervals or just before the attacks. When it is necessary to prolong their use and increase the dose the preference should be given to the soda salt as it is less toxic and has no effect upon the heart. The taste of these preparations is not disagreeable and they are well tolerated by the stomach.

### EXCORIATIONS IN CHILDREN.

In *L'Union Médicale*, No. 37, 1893, the following ointment is spoken highly of in the excoriations of children:

℞ Salicylic acid.....5 dgms (grs. viij)
Subnitrate of Bismuth.....8 gms (℥ij)
Starch.....6 gms (℥jss)
Rose ointment.....30 gms (℥j)

For external use.

### SULPHATE OF SPARTEINE.

Dr. Rhode (*Gazette des Hôpitaux*, No. 125, 1893), presents the following rules for the employment of the sulphate of sparteine both as a heart tonic and as a diuretic. A dose of five cgms. per diem has always been sufficient in his experience to produce diuresis. In some cases it has been of advantage to associate it with digitalis, convallaria or strophanthus. Association of these diuretics, given in small doses, will yield one results, in rebellious cases, which would not be obtained by single massive doses of any one alone. It also permits one to continue treatment for several weeks. By giving one cgm. of sparteine four to five times a day, the effects begin to be felt after twenty-four hours. As with digitalis an increase of arterial pressure precedes the diuresis. Sometimes a diminution of the pulse rate has been observed where it was accelerated from some pathological cause, but the slowing as remarked after digitalis, has not been observed. It may also be employed in subcutaneous injections, for injections of a 2:100 solution cause neither pain nor inflammation. Its effect upon the pulse is apparent after a few minutes. The quantity of albumen may also diminish after its use, even to complete disappearance. This diminution is real and not apparent from dilution of the urine.

### A DIURETIC IN CARDIAC AND RENAL DROPSY.

In *La Riforma Medica*, 1893, IV, No. 25, as a diuretic in cardiac and renal dropsy, the following formula is warmly recommended:

℞ Fl. Extr. jalap
Fl. Extr. squills.....ää 15 gms. (℥iv).
" jaborandi..... 30 " (℥j).
" digitalis,.....gtts. xxx
Nitrate of potash..... 20 " (℥v).
Angelica wine..... 60 " (℥ij).

A tablespoonful every three hours.

### CHRONIC RHEUMATIC THROAT DISEASES.

Dr. A. Hecht (*Wiener Medizinische Presse*, No. 1, 1894), directs attention to the existence of chronic rheumatic throat diseases and records such a case. A woman of twenty-five years, had suffered or two and a half months, from difficultyf n swallowing, which however, was noti constant. In the morning she could eat her breakfast without pain but when she worked the whole day in the field or was exposed to cold weather pain increased

*In charge of the translator, F. H. Pritchard, A. M., M. D.

considerably. The pain was not always of the same intensity and changed about, now being on the right and then on the left side. Examination of the throat and larynx revealed nothing and hysteria could be excluded. She also complained of pain in the muscles of the back of the neck, and the lateral surfaces of the thyroid cartilage were also sensitive to pressure. As the pain was complained of in the one or the other side the corresponding portion of the faucial arch was painful and reddened. Salicylic acid yielded no results. The disease was first described by Fletcher Ingals, and its characteristic feature is pain in the small muscles and the connective tissue between them and the cartilage, radiating from here to the clavicles. In most cases the pain does not extend over these bounds, but is limited to special parts, principally the posterior arch of the palate, the hyoid bone, especially its large cornua and lateral surfaces. The pain was intermittent and quite severe during changes of weather. On pressure painful points could be made out, degultition was most always, and speaking sometimes, painful. The back and sides of the neck were also occasionally affected. Locally there was more or less redness. Treatment of this obstinate disease is to be directed to the diathesis. Internally salol and the salicylate of soda are to be employed, while locally the following formula is of service:

℞ Muriate of morphine.....25 cgms. (grs. iv).
Carbolic acid
Tannic Acid.....āā 2 gms (gtts. xxx.).
Glycerine,
Distilled water.....āā 15 " (℥iv).

To be applied locally every two or three days.

He effected a cure, in his case, by these means.

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### PITYRIASIS OF THE EARS AND ITS TREATMENT.

Dr. Albespy (*La Semaine Medicale*, No. 66, 1893), calls attention to this rare disease. It is a desquamating dermatitis of the external auricle and the outer auditory meatus. There is slight desquamation; it is rough to touch, as though the ear had been frozen. Cerumen is no longer formed. The whitish or grayish scales are thicker at the centre than at the periphery and may accumulate in the meatus in the form of a plug. Subjectively the patients complain of itching, roaring in the ears, difficult hearing, a sensation of warmth in the ear, and sometimes of facial neuralgia, from irritation of the endings of the trigeminus in the external ear. It might be confused with the affection described by Wreden as keratitis obturans or seborrhoeic eczema. In the former the disease affects chiefly the deeper portions of the external ear, and with the latter there are vesicles secreting moisture. In pityriasis, the scales on the inner surface present the characteristic streak and it is not observed before the twentieth year. It is due to extension of the disease from the hairy scalp. The hairs in the meatus should be either extracted or cut off and the scales removed by a luke-warm boric acid solution. A pledget of cotton, dipped into a five per cent. solution of nitrate of silver, is then introduced into the ear and left there for twenty-four hours. After this is removed the underlying skin is found to be red but not bleeding. This tamponade is continued until desquamtion no longer takes place, and the walls have become smooth. This once attained, tampons dipped in the following are employed:

℞ Salicylic acid.....3 gms. (grs. xlv).
Canada balsam.....1 " (gtts. xv).
Collodion.....16 " (℥iv).

Under the influence of these tampons, renewed every four to five days, the redness disappears and the epidermis gradually regenerates. Treatment is finished by insufflations of air. Internally one may administer preparations of arsenic.

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### TREATMENT OF CONDYLOMATA.

Dr. Gemy (*Riforma Medica*, No. 22, iv., 1893) recommends where the removal of acuminate condylomata is impossible, the local application of an astringent powder consisting of equal parts of salicylic acid and powdered sabina. Before its application the affected parts should first be energetically bathed with warm water, to which about six per cent. of Van Swieten's solution has been added. After the local bath, dry them carefully with sublimated cotton before application of the astringent powder. He regards the acuminate condylomata as the product of a coccidium.

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### PEROXIDE OF HYDROGEN IN STOMATITIS.

Dr. Boennecken (*Wiener Medizinische Presse*, No. 4, 1894) recommends the

peroxide of hydrogen very warmly in the treatment of stomatitis. It will immediately prevent, in a moderately low per cent. solution, development of micro-organisms and has the advantage of not irritating the mucous membranes. A two to three per cent. solution generally suffices, for even if greatly diluted, it possesses strong antiseptic qualities; even a 1:20000 solution, hindering the development of the micro-organisms of putrefaction. If one have a patient with stomatitis, irrigate the mouth with a two per cent. solution for a few minutes and the former penetrating odor will have disappeared. After twenty-four hours use the purulent coating on the ulcers of the edges of the gums will have been cast off, and in forty-eight hours they will have begun to cover with a layer of epithelium. In five to six days even severe cases may be caused to heal.

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### ICHTHYOL IN DISEASES OF THE GENITO-URINARY TRACT.

Dr. Lohnstein (*Allgemeine Med. Central Zeitung*, No. 103, 1893) has employed ichthyol in genito-urinary affections, and comes to the following conclusions:

1. Ichthyol is an excellent remedy in acute urethritis, in a ½ to two per cent. solution in warm injections, and even in cases where the mucous membrane is especially irritable.

2. In subacute anterior urethritis and above all, in superficial circumscribed affections, it renders excellent service if it can be applied locally through the endoscope.

3. In infiltrating forms of chronic urethritis it is inactive, but on the contrary, it will be of value if alternated with mechanical measures of treatment.

4. In prostatitis, in the form of suppositories, in doses of three to five dgms. (five to seven grains) it removes the inflammatory and irritative phenomena.

5. In pyelitis and nephritis it exerts no beneficial action.

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### DANGERS OF COCAINE SALVES.

In the *Medinicische Neuigkeiten*, (No. 2, 1894) it is stated that a salve or solution of cocaine, even of two per cent., if applied to the breasts of nursing women, will produce erection of the nipple and, what is worse, a suppression of the milk. This suppression is only temporary and disappears after discontinuence of the drug, yet it seems advisable to warn against employing cocaine in the treatment of fissures of the breast in nursing women.

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### ANTISEPSIS OF FISSURES OF THE NIPPLE.

Dr. Lepage (*La France Médicale*, No. 4, 1894) claims that the prophylactic treatment of fissures of the nipple is almost an illusion, but it is possible in abscesses of the breast. Compresses, wet with a saturated solution of boric acid, are valuable agents in prevention of mammary abscesses, if they be only continuously applied. He recommends the following solution:

℞ Sterilized water.....450 gms (℥xiv)
Glycerine.....500 gms (℥xvij)
Alcohol.....50 gms (℥jss)
Biniodide of mercury....10-20 dgms (grs. jss-iij)

Since this solution has been employed at the Maternity of Baudelocque, in Paris, the morbidity of nursing mothers has greatly decreased and the health of the children also has been in general improved, as the mothers suffer less and nurse better and more frequently.

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### TREATMENT OF NEURALGIA.

Prof. Dujardin-Beaumetz (*Rivista Clinica Terapeutica*, No. 12, 1893) advises the following treatment of neuralgia:

Administration of antithermic and analgesic remedies. In hemicrania, antipyrine is to be preferred, while in pains from compression, lightning-like pains and dental neuralgia, acetanilid is the best remedy. In pure neuralgia exalgine is preferred by him. In pains of neuropathic origin phenacetine acts best. Antipyrine is prescribed in daily doses of one to four grams (fifteen grains to one drachm.) Acetanilid is administered in a daily dose of twenty-two grains in three powders. Exalgine is best given in the following formula:

℞ Exalgine,.....2. 50 gms. (grs. xxxvij).
Tinct. of Melissa,..... 10 gms. (℥ijss).
Syrup of Orange Peel,.....150 gms. (℥v).
A ℥bupspoonful morning and evening.

Phenacetine is administered in single doses of seven to fifteen grains, of which two to three are taken in twenty-four hours.

# SELECTED.

## MALPRACTICE AS DEFINED BY LAW.*

The following extracts are taken from the official report of the address on "Malpractice with Reference to the Legal and Medical Professions." They present an interesting definition of the relations of the professions of law and medicine, and of the responsibility which both bear to the public:

### IMPLIED OBLIGATIONS OF THE PROFESSIONS.

The obligation of the two professions is the same. Physicians, surgeons, dentists, druggists and lawyers, by holding themselves out to the world as such, impliedly contract that they possess the reasonable and ordinary qualifications of their profession, and are consequently under a duty to exercise reasonable and ordinary care, skill and diligence toward those who employ them. The world has not time to inquire into the proficiency of every professional man; hence, it presumes him to be furnished with that amount of skill which he is under obligation, by virtue of his calling, to possess. It may and does vary widely among men, but it must at least be sufficient to entitle him to a recognized place among his own fraternity. If, therefore, by illegally assuming a title, or assuming one he is incompetent to fill, he holds himself out as a practitioner of any science, when he does not possess the required qualifications, and induces the public to employ him, he is a wrongdoer *ab initio*, and any person injured by his performances has an action against him.

The courts have ruled that no attorney can be held to infallibility of judgment or to a warranty of the result of his efforts. Attorneys do not profess to know all the law or to be incapable of error or mistakes in applying it to the facts of every case, as even the most skillful of the profession. What he is responsible for is ordinary skill, diligence and care, having reference to the nature of the business he undertakes to do, and for any failure to exercise these, an action may be maintained by his client against him.

*Delivered before the Society of Medical Jurisprudence at the Academy of Medicine, November 13, 1893, by Hon. David McAdam, Judge of the New York Superior Court.

### MALPRACTICE DEFINED.

Malpractice is bad or unskillful practice in a physician or other professional person whereby injury is caused. Blackstone says concerning it: "For it hath been solemnly resolved that malpraxis is a great misdemeanor and offence at common law, whether it be for curiosity and experiment or by neglect, because it breaks the trust which the party had placed in his physician, and tends to the patient's destruction" (3 Black. Com., 122).

Malpractice may be divided into three parts—1. Wilful; 2. Negligent; 3. Ignorant.

Wilful takes place when the physician purposely administers medicines or performs an operation which he knows and expects will result in damage or death to the individual under his care.

Negligent malpractice comprehends those cases where there is no criminal or dishonest object, and includes gross negligence of that attention which the situation of the patient requires.

Ignorant malpractice is the administration of treatment calculated to do injury, and which does harm, and that which a scientific medical man would know is not proper.

Malpractice can only be affirmed where the physician has set aside established principles and neglected to employ means which are universally held to be necessary in the given case. If medical men fail to discharge their duty in a skillful and attentive manner, the law will grant redress to the party injured by their neglect or ignorance, in the form of an action on the case, as for a tortious misconduct, and no fees can be recovered.

### TESTS OF RESPONSIBILITY.

From the leading cases the following propositions may be extracted:

1. If the defendant acted honestly and used his best skill to cure, and it does not appear that he thrust himself in the place of a competent person, it makes no difference whether he was at the time a regular physician or surgeon or not.

2. To constitute guilt, gross ignorance or negligence must be proved.

3. A defendant who, with competent knowledge, makes a mistake in a remedy is not answerable; but it is otherwise when a violent remedy, shown to have occasioned death, is administered by a person grossly ignorant, but with average capacity, in which case malice is presumed.

4. Where competent medical aid can be had the application of violent remedies by an ignorant person, though with the best of motives, involves him in criminal responsibility.

5. Express malice, or an intent to commit a personal or social wrong, always makes the practitioner criminally responsible. As physic and salves were in use before physicians and surgeons, the common law provided that if a party employ a person as a surgeon, knowing him not to be one, he had no civil remedy; yet if a person of no medical education, in a case where professional aid might be obtained, undertakes to administer medicine which may have a dangerous effect, and thereby occasions death, such person is guilty of manslaughter.

Many of these matters are now regulated by statutes, which prescribe the rights and liabilities of medical men, and those who assume to practice as such without the necessary credentails. These provisions in the different states are, of course, controlling. In an action against a physician for malpractice the question is not whether he is skilled in his profession, but whether he treated this particular case properly. The question of skill in his profession is material, but not controlling, the main contention being whether he treated the case in hand according to scientific principles.

The physician has no exclusive privilege of absolution from wrong-doing. He derives none from his profession, and becomes responsible, therefore, for any damages to the health or for any disfigurement of the person of a patient, which are directly traceable to his want of skill or diligence.

### WHAT CONSTITUTES SKILL AND DILIGENCE BY MEDICAL MEN.

The reasonable and ordinary care, skill and diligence which the law requires of physicians and surgeons is such as physicians and surgeons, in the same general neighborhood, in the same general line of practice, ordinarily have and exercise in like cases. In a Pennsylvania case a surgeon was sued for alleged malpractice in the setting and treatment of a broken limb. The court charged the jury "that the defendant was bound to bring to his aid the skill necessary for a surgeon to set the leg so as to make it straight and of equal length with the other, when healed; and if he did not he was accountable in damages, just as a stonemason or bricklayer would be in building a wall of poor materials, and the wall fell down; or if they built a chimney and it would smoke by reason of want of skill in its construction. They could not only recover for building, but would be accountable for damages." This ruling was reversed no appeal, and the Appellate Court laid down this rule:—

"The implied contract of a physician and surgeon is not to cure—to restore a limb to its natural perfectness—but to treat the case with diligence and skill. The fracture may be so complicated that no skill vouchsafed to man can restore original straightness and length; or the patient may, by wilful disregard of the surgeon's direction, impair the effect of the best conceived measures. He deals not with insensate matter, like the stonemason or bricklayer, who can choose their materials and adjust them according to mathematical lines; but he has a suffering human being to treat, a nervous system to tranquillize and a will to regulate and control."

The true measures of skill required is that ordinarily exercised in the profession by the members thereof as a body—that is the average of the reasonable skill and diligence ordinarily exercised by the profession as a whole, not that exercised by the thoroughly educated nor well educated.

The medical man must not only possess the required skill, but must exercise it in the case at hand, and in the manner best calculated to bring about beneficial results.

### DIFFERENT SCHOOLS OF MEDICINE.

The law does not favor any particular school of medicine, and the treatment of a physician is to be tested by the principles of that school to which he belongs.

Homeopathy and allopathy now stand on the same footing before the law.

To constitute a school of medicine under this rule, it must have established rules of practice for the guidance of all its members, as respects principles, diagnoses and remedies, which each member is supposed to observe in any given case. If the practitioner proceeds without such a system of fixed principles or formulated rules, he does not belong to "a school of medicine," and he is held to the duty of treating his patient with the ordinary skill and knowledge of physicians in good standing who practice in his vicinity.

SKILL REQUIRED OF EMPIRICS.

One not a regular physician, but holding himself out as capable of treating particular maladies, is bound to exercise the skill and care of the general physician in the treatment of such maladies. This upon the ground that the law makes no allowance for quackery; it demands qualifications in the profsesiôn, and will require empirics to make their professions of skill and ability good, or answer for the consequences. The same rule has been applied to clairvoyants. For unskilfull treatment the attendant is liable.

As Lord Ellenborough said: The farrier who undertakes to cure my horse must have common skill, at least, in his business, and that is implied in his undertaking. * * * A surgeon would be liable for ignorance, and justly responsible for damages, for having adventured upon the exercise of a profession without the ordinary qualifications of skill, to the injury of a patient.

It is sufficient to sustain a verdict that the party held himself out as a physician. Issuing circulars signed with his name having "Dr." prefixed is enough.

LIABILITY OF VOLUNTEERS.

A person who, without special qualifications, volunteers to attend the sick can, at most, be only required to exercise the skill and diligence usually bestowed by persons of like qualifications under like circumstances. Thus (to put a case borrowed from Mohammedan law), "If a person will knowingly employ a common mat maker to weave or embroider a fine carpet he may impute the bad workmanship to his own folly." In other words, a patient is generally entitled to receive that which you lead him to believe he may expect.

EFFECT OF LOCALITY UPON STANDARD OF SKILL.

As the law discriminates between the metropolitan and rural bar, so it distinguishes between the city and country physician, by providing that the locality in which a physician or surgeon practices is to be taken into account. One practicing in a small town or sparsely settled country district is not to be expected to exercise the care and skill of one residing in, and having the opportunities afforded by, a large city. He is bound to exercise the average degree of skill possessed by the profession in such localities generally.

The term "rural practitioner" here used, refers to those who practice in small towns away from the facilities of the "metropolitan practitioner," and not to those in populous places near the cities where the opportunities of the different practitioners are equal. Negligence is the absence of care, according to the circumstances; and the law, exacting as it is in many matters, does not require impossibilities, nor hold people to implied responsibilities, which, in the nature of things, they never intended to assume. The implied obligation in this regard may be said to be that which both parties must have understood, but did not deem necessary to express.

STATUS OF SPECIALISTS.

A professional man who devotes himself to a particular branch of his calling, legal, medical or surgical, and holds himself out as a specialist therein, impliedly undertakes that he possesses superior knowledge and ability in respect thereto as well as its technics, and the degree of skill demanded of him must, in the nature of things, conform to the grandeur of his representations, express or implied.

An oculist may be held liable for failure to exercise as high a degree of skill as other surgeons of that specialty exercise when he holds himself out as possessing such skill.

NO IMPLIED WARRANTY TO CURE.

We have found that the lawyer neither guarantees the success of his proceedings in a suit nor the soundness of his opinions. The same rule applies to the medical man.

There is no implied warranty on his part that he will effect a cure. Failure of a surgeon to accomplish the desired result

does not of itself render him liable for malpractice; the test is whether he has exercised reasonable skill and attention in his treatment. His obligations, like that of the lawyer, is merely to bring to the case in hand the average skill of the profession in the vicinity, with the care commensurate to its importance and the consequences likely to follow.

ERRORS OF JUDGMENT.

Medical men, like lawyers, are not liable for mere errors of judgment, unless it be so gross as to be inconsistent with reasonable care, skill and diligence.

Thus in Fisher *vs.* Nicholls, (2 Ill. App., 484), the appellant asked the court to instruct the jury, "that if they believe the defendants used ordinary skill and care in the treatment of the plaintiff's hand, and made a mistake in judgment, then the defendants are not liable for the result of such mistakes under the law." This instruction the court refused to give as asked, but gave it with the following modification: "Provided the defendants, in making up their judgment, did not disregard the well settled rules and principles of medical science." This request as modified, conforms to the rule already laid down concerning the skill to be bestowed by the medical man to his patient.

The burden of proof is upon the plaintiff in all actions for malpractice to show that there was a want of due care, skill and diligence, and that the injury was the direct result of such want of care, skill and diligence.

The mere failure to affect a cure raises no presumption of a want of care or skill.

A physician and surgeon engages to bring to the treatment of his patient care, skill and knowledge, and while, when exercising these, he is not responsible for mere errors in judgment, he is chargeable with knowledge of the probable consequence of an injury, or of neglect in his treatment or unskillful treatment.

ERRORS IN DIAGNOSIS.

An error in diagnosis is sure to be followed by improper treatment, and is, therefore, of importance.

The courts have held that the right of a physician to be compensated for his services depends upon the diligent exercise under his employment of the skill which commonly pertains to his profession; that the rule applies as well to the ascertainment of the patient's disease as to its treatment, and the fact that the physician erred as to the disease and treated the patient for one he did not have, will not defeat the physician of compensation.

A surgeon possessed of the requisite knowledge is not responsible for errors of judgment or mistakes in a case in which there are reasonable grounds of doubt and difference of opinion, but is chargeable only with error arising from want or failure to exercise reasonable skill and diligence.

In Gedney vs. Ringsley (41 St. R.; 794 s. c., 16 Supplt, 792), it appeared that the plaintiff injured her arm, and defendant (a surgeon) examined it, but discovered nothing more serious than a bad bruise. In fact, the arm was fractured, and by reason of the delay in discovering the fracture the injury became irreparable. In an action for damages the defendant's evidence tended to show that the arm was so swollen that a complete examination could not be made, and that plaintiff told him not to call again until she sent for him. Held, that if this were found to be true, no recovery could be had.

CONSENT TO SURGICAL OPERATIONS.

If physicians attending a woman deem it necessary, for the preservation and prolongation of her life, to perform an operation, they are justified in doing so if she consents, whether her husband consents or not. As a rule, anything warranted by good practice and not objected to by the patient is authorized. This is evidenced by the numerous operations constantly performed in efforts to save or prolong life, some of which result disastrously, and yet no one would impute either malpractice or manslaughter. These are more than offset by the numerous, and sometimes marvellous, results of a beneficial character brought about by similar operations upon others.

GRATUITOUS SERVICES.

The mere fact that a physician or surgeon renders services gratuitously does not affect his duty to exercise reasonable and ordinary care, skill and diligence.

Treating a patient gratuitously gives no license to experiment on him or to do any negligent act toward him. He puts him-

self in professional hands, and has the right to expect medical treatment according to the ability of the physician or surgeon in charge. "It is the duty of every artificer to exercise his art rightly and truly as he ought." This is peculiarly the duty of professional practitioners, to whom the highest interests of man are often necessarily intrusted. The law has no allowance for quackery. It demands qualification in the profession practiced, not extraordinary skill, such as belongs only to a few men of rare genius and endowments, but that degree which ordinarily characterizes the profession.

A physician employed by a city to treat patients in an almshouse will not be relieved from liability to a patient therein for failure to exercise ordinary care and skill, although he is paid by the city and not by the patient.

CONSULTATION WITH OTHERS.

If a physician or surgeon is not competent, or feels that he is not competent, to treat a case properly, it is his duty to recommend the employment of another, but if he is competent and so considers himself, and is in doubt concerning the case, he should use his best judgment as to consultation with other physicians or surgeons. He cannot bring in consulting physicians or surgeons without the consent of the patient, so as to obligate him to pay their fees, unless, perhaps in a very extreme case, where dire necessity furnishes the authority.

ADOPTION OF LATEST METHODS AND APPLIANCES.

Physicians and surgeons should keep up with the latest advance in medical science, and use the latest and most improved methods and appliances, having regard to the general practice of the profession in the locality where they practice, and it is a question for the jury to decide from all the circumstances of the case whether the physician or surgeon has fulfilled his duty in that respect.

If they depart from generally approved methods of practice, and the patient suffers an injury thereby, the medical practitioner will be held liable, no matter how honest his intentions or expectations were of benefit to the patient.

The failure to use the most improved methods is not conclusive evidence of negligence, if those used were reasonably safe, and such as were employed by other reputable practitioners in the neighborhood, no liability is incurred. Yet it is advisable for all to recognize the progress of science and keep abreast of it to avoid charges which are easily made and are lasting in their effects, though unwarrantable by the facts.

PARTNERSHIP LIABILITY.

All the partners are liable for malpractice by any member of the firm. The ground of liability is, the contractual relation, for the gist of the action is its breach either by malfeasance or misfeasance.

It will not do for an eminent practitioner to associate himself in business with a "quack," and after holding him out as a competent practitioner, impose upon the public and then be allowed to avoid the responsibility. Many people might be induced to receive treatment from the partner of a well-known practitioner, who would never have thought of employing him, but for the partnership relation and the holding out of the individual as one worthy of such association. While malpractice is a tortious act, the true source of liability is the contractual relations, which is with the firm, and it must answer for its breach. In other words, it must take the burdens with the benefits.

This doctrine of privity of contract does not confine the remedy to the employer; for if a surgeon treat a child unskillfully, he will be liable to the child, even though the parent contracted with the surgeon.

CONTRIBUTORY NEGLIGENCE OF PATIENT.

If the patient in any way contributes to the injury by his fault or neglect, he cannot recover for malpractice by the physician or surgeon.

If the patient by refusing to adopt the remedies or comply with the directions of physicians, frustrates, or defeats the endeavors of the physician, or if he aggravates the case by his misconduct, he cannot charge to the physician the consequences due directly to himself.

When a liability for malpractice is established, proof that the patient, after the liability was incurred, disobeyed the orders of the physician, and so aggravated the injury, does not discharge the liability; it simply goes in mitigation for damages.

DOCTORS MUST KEEP SOBER.

There is no law except that of propriety, which requires a lawyer to remain sober; but an express statute enjoins this upon the medical fraternity in these words: "A physician or surgeon, or persons practicing as such, who, being in a state of intoxication, administers any poison, drug or medicine, or does any other act, as a physician or surgeon, to another person by which the life of the latter is endangered or his health seriously affected, is guilty of a misdemeanor." Another section provides: "A physician or surgoon, or persons practicing as such, who being in a state of intoxication, without a design to effect death, administers a poisonous drug or medicine, or does any other act, as a physician or surgeon, to another person which produces the death of the latter is guilty of manslaughter in the second degree." Medical men who decline to drink on account of these admonitions may be looked upon, therefore, as models of "statuary sobriety."

DOCTORS SHOULD BE LAWYERS, AND VICE VERSA.

Blackstone, in his "Commentaries," says: "The science of medical jurisprudence has of late years attained to special prominence and importance; inasmuch, also, as the evidence of skilled witnesses is justly deemed entitled of much weight, some general acquaintance with legal principles and the nature of criminal offenses is suggested for those professing the faculty of physic as desirable and useful." Apropos to this let us add the suggestion that inasmuch as there are many cases of contested wills in which the testamentary capacity of the testator is called in question, and many cases of especial prominence and importance wherein the mental condition of the principal party is directly in issue, some general acquaintance with the medical science, and the nature, cause and effects of such things, is suggested for those professing the profession of the law as not only desirable and useful, but necessary to the proper presentation and protection of the rights of their client, and the proper cross examination of the medical experts. The one would seem to follow the other as the night the day.

QUACKS AND SHYSTERS.

To call a person lawfully practicing as a physician a "quack" is in effect charging him with a want of the necessary knowledge and training to practice the system of medicine he undertakes to bestow. In other words, a "quack" is an ignorant pretender to knowledge he does not possess. The term "shyster" has practically the same meaning in the legal profession. Thus, in Wakley vs. Healy, 7 C. B., 591, it was held that publishing in writing of a barrister, that he was "a quack lawyer and imposter" is actionable.

The word "shyster"—defined by Webster to mean a trickish knave, one who carries on any business, especially a legal business, in a dishonest way—is evidently capable of having reference to the professional character and standing of a lawyer.

In an action of libel it was said that the designation "pettifogging shyster" must mean an unscrupulous practitioner who disgraces his profession by doing mean work, and resorts to sharp practice to do it.

It would be a good thing for the public, as well as for the two learned professions, if the ignorant pretenders referred to were obliged to designate themselves "quack doctors" and "shyster lawyers" upon their signs and cards. The government, during the war, stamped upon every bogus greenback it came across the word "counterfeit." These cabalistic marks prevented imposition.

The suggestion made, if carried out, would save the good name of the legal and medical professions from much of the abuse they now receive.

LEGAL POSITION OF DENTISTS.

The teeth and the gums of the mouth are important parts of the human body. The pulling of teeth is an art or profession akin to surgery. Indeed those engaged in it are known as "surgeon dentists," and the same degree of skill is exacted of them as of the other professional men, and, substantially, the same rules govern their operations.

In Keily vs. Colton, the defendant, who was a dentist, undertook to extract a tooth while the patient was under the influence of an anæsthetic called "laughing gas." In extracting the tooth the forceps slipped and part of the tooth went down the plaintiff's throat, causing coughing and

vomiting, which continued at intervals for about four weeks, at the end of which time, during one of these attacks of coughing, the tooth was thrown up and relief followed. Held, that while the patient was under the influence of an anæsthetic, which deprived him of the use of his faculties, the defendant was required to use the highest professional skill and diligence to avoid probable dangers, and that the circumstances presented were sufficient to warrant the finding by the jury of negligence.

LIABILITY OF DRUGGISTS.

The rule of libility of a druggist who delivers a deleterious drug to one who calls for a harmless one is the same as that which governs the liability of professional persons whose work requires special knowledge and skill, and a person is not legally responsible for any unintentional consequential injury resulting from a lawful act when the failure to exercise due and proper care cannot be imputed to him.

An action against a druggist for an error of his clerk in compounding a prescription rests upon negligence, and a right of recovery does not arise from the mere fact that a drug given was not included in such a prescription, as the defendent is entitled to have the question of the competency of his clerk and the exercise of due and proper care on his part submitted to the jury.

In such case, when the defendant assumes to fill the prescription, undertakes that he possesses the ordinary skill of a druggist or apothecary, and that he will exercise due and proper care in putting up the medicine required, the degree of care being proportionate to the gravity of the injury that would necessarily result from a want of care, the failure to exercise due and proper care is the only ground upon which a recovery can be had in such action.

One who is ignorant of the properties of a poisonous drug is liable to a criminal prosecution for a negligent sale or use thereof.

A druggist who grinds medicines in a mortar which has been used to grind poisons without properly cleansing it, is liable to one injured by means of such careless use. So of a druggist on shipboard who neglects cleansing drinking utensils after using them with poisonous substances. So of a druggist who sells morphine instead of quinine, which causes death.

A druggist who sells a deadly poison as a harmless medicine is liable, and one who labels a deadly poison as a harmless drug is liable for all consequences.

LIABILITY OF CORPORATE INSTITUTIONS.

While the attending physician may be liable for malpractice it does not follow that counties are in reference to poorhouses, nor hospital corporations or proprietors in reference to their institutions. Thus, in Harris vs. Woman's Hospital (27 Abb. N. C., 37; s. c., 39, St. R., 98; 14 Suppt., 881), it was held that a public charitable hospital is not liable for injuries sustained by an inmate from the actual negligence of a medical attendant, if it is shown that the institution exercised due care in the selection.

REQUIREMENTS OF EVIDENCE.

Whether a physician has in a given case adopted the proper treatement is a question on which the opinions of medical men of the same school may be received in evidence, and they may state whether, in their opinion, the treatment was proper or not. In other words, whether it was in conformity to the practice of the profession.

A defendant may state what, from his study and experience, he deems proper treatment of the case in question, but not what success he had in other cases. The chief reliance in malpractice cases must be medical testimony, which, in the nature of things, comes from other members of the profession, and is of the character known as the testimony of experts, and consists of opinions founded on facts, observations and the like.

An expert cannot be required to pass upon or draw inferences from the evidence given by another witness.

An expert may be qualified by study without practice, or by practice without study. But mere observation without either is insufficient. Expert evidence, though useful as a guide, depends upon its value as found by the Court or jury, and is never conclusive, as the Court or jury may apply their own experience and good judgement to the subject.—*R. I. Med. Sci. Mo.*

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SATURDAY, MARCH 17, 1894.

## EDITORIAL.

### INTERNATIONAL SANITARY CONFERENCE.

The Sanitary Conference is a remarkable demonstration of the importance in public affairs achieved by modern medical science. The Conference, now being held in Paris, is not a gathering of reformers to propagate a pet theory, but is a meeting of medical experts, who are the official representatives of a number of governments. It is not the first assemblage of sanitary experts seeking the same end, as similar conferences had previously been held at Constantinople, Rome, Venice, and more recently at Dresden; but the present conference is peculiar in the latitude of its powers and in the authority conferred upon it by the participating governments. The object sought by such conferences has been measures for preventing the spread of infectious and contagious diseases, especially those of an epidemic form; and the object of the present meeting is to formulate and recommend measures which can be universally enforced to prevent the spread of such diseases, with special present reference to cholera.

At the Dresden conference it was decided that whenever cholera broke out in any country, other nationalities should be notified of the fact at once. This rule, however, has not been observed, as is evidenced by the strenuous efforts of the French authorities to conceal the prevalence of cholera at Marseilles last year. In February, 1893, there were 102 deaths from cholera at Marseilles and foreign governments were not duly warned. Again the epidemic broke out in May and lasted during the summer months causing 767 deaths, and yet nothing was done. That the United States was spared an invasion of cholera from this source, must be attributed to the very efficient enforcement of the provisions of the new national quarantine law, so ably carried out under the direction of Surgeon-General Wyman, U. S. M. H. S.

The Paris conference is composed of the representatives of seventeen different nations, including the United States, the principal European powers, British India, Persia and Turkey.

Experience has shown the futility of attempting to prevent the spread of cholera and at the same time permit the sources of the epidemic to remain in full activity.

Much may be done by the enforcement of quarantine measures to mitigate the ravages of the epidemic, but to stamp out the disease requires the elimination of its starting point. The necessity of going to the root of the evil involves many questions not only of science, but diplomacy, and is especially difficult from the fact that it concerns the religious convictions of an immense proportion of the population of the Eastern world.

It is agreed that the principal centre from which cholera spreads in all directions, is Mecca, the Holy city of the Mohammedan. That Mecca is the objective point of pilgrimages from all portions of the Eastern world, accounts for the concentration of cholera in that city, brought there by pilgrims and carried from thence by returning pilgrims. A pilgrimage of Mecca is the religious ambition of every follower of the Prophet. To have accomplished such a pilgrimage assures the Mohammedan of religious distinction. To die in the effort to become Hadji, insures entrance to Paradise, and as the Mohammedan is a fatalist, neither death, nor hell, nor any other creature can dissuade him undertaking the trip to the Holy city.

To succeed in regulating these pilgrimages and enforcing the simple precautions necessary to prevent cholera reaching Mecca and spreading from thence over the entire world, without precipitating a terrible religious war, requires the active and constant cooperation of the Turkish and Persian governments. It will not be an easy matter to enlighten these governments and arouse them to continuous and intelligent action.

The success of the British government in anticipating and preventing the inevitable epidemic of cholera following the great Indian Fair at Hardwar, by the strictest enforcement of inspection, isolation and other sanitary measures, shows that the epidemic may be prevented, even at the start; and that too, without seriously interfering with the coming and going of the population. The suppression of cholera at Hardwar, will be of considerable aid in handling the situation at Mecca, not only by force of example but because the fair at Hardwar brought together people from all parts of India, the home of cholera, thus furnished a most effective centre for its propagation throughout the world and, because of the large number of Mohammedan residents of India, became the direct source of supply of cholera to Mecca.

Mr. Earnest Hart, in his articles on cholera, has given a most vivid presentation of the filthy and unsanitary conditions existing at Mecca, and of the inconceivably disgusting practices of the pilgrims in their efforts to secure holiness. And he has likewise shown that the difficulties of securing the proper sanitary conditions are spiritual rather than material, as the physical aspects of the locality present no mechanical obstacles.

In 1881, a quarantine station was opened on the island of Camaran, at the entrance of the Red Sea. Curiously enough, cholera has been more prevalent since the opening of that station than it was before. For instance, there were epidemics in 1865, '66, '72 and '76, before the establishment of this station. Since then, cholera has been epidemic in 1881, '82, '83, '90, '91 and '93; or, during the twelve years preceding the establishment of this quarantine station for the pilgrims there were four epidemics of cholera at Mecca, and during the twelve years following its establishment, there have been six cholera epidemics. This fact, however, does not operate against the importance of establishing sanitary precautions, but it does most thoroughly demonstrate the criminal folly of making an image of science and worshiping it under the belief that it is a potent spirit.

It is to be hoped that the Paris conference will succeed in devising measures that will accomplish the desired end.

# ABSTRACTS.

## LEGAL REQUIREMENTS FOR THE PRACTICE OF MEDICINE IN THE UNITED STATES.

So many changes have been made in the legislation regulating the practice of medicine in this country during the past three years, that the Illinois State Board of Health will include, in its forthcoming Report on Medical Education, the text of all laws on this subject in force at the beginning of the present year in the several States and Territories of the United States, and in the provinces of the Dominion of Canada. From this forthcoming Report, through the courtesy of the Secretary of the Board, Dr. J. W. Scott, some data have been gathered which will be of interest to the spring crop of new graduates, and to medical men generally.

Of the six New England States, Maine, Massachusetts, New Hampshire and Rhode Island have no legal requirements for the practice of medicine. Connecticut has adopted a medical practice act which went into effect Oct. 1, 1863, and in Vermont the law requires the registry of a diploma indorsed by a Board of Medical Censors or of a certificate of satisfactory examination by one of these Boards.

Exclusive of the four States first named, the other States and Territories may be roughly grouped into the following three classes:

In Alabama, Arkansas, Florida, Maryland, Minnesota, Mississippi, New Jersey, New York (act of May 9, 1893), North Carolina, North Dakota, Pennsylvania (after March 1, 1894), South Dakota, Texas, Utah, Virginia and Washington, the diploma confers no right to practice and has no legal value, except, in some cases, to give its professor standing before an examining board. The right to practice in each of these sixteen States is determined by individual examination before boards of examiners created by law.

In California, Colorado, Connecticut (since October, 1893), Delaware, Illinois, Iowa, Kentucky, Louisiana, Missouri, Montana, Nebraska, New Mexico, Oklahoma, Oregon, Tennessee, Vermont and West Virgina, the diploma is subject to supervision of some designated body vested by law with authority to determine its validity as evidence of its possessor's qualifications for the practice of medicine. Failing the possession of such a recognized diploma, the right to practice may be acquired by passing a satisfactory examination.

In Arizona, Georgia, Idaho, Indiana, Kansas, Michigan, Nevada, Ohio, South Carolina (since the repeal of the Act of 1888), Wisconsin and Wyoming, the presentation of any kind of a diploma—provided only that it be from a "chartered" medical institution—is the sufficient warrant in law for country clerks, clerks of courts, registrars of deeds and similarly qualified judges of medical fitness to admit to practice.

Following is a résumé of the legal requirements for practice in each State and Territory of the United States, in force Jan. 1, 1894:

Alabama.—A certificate of successful examination by the State (or a county) Board of Medical Examiners. Diplomas confer no right to practice.

Arizona.—Registry, with a county recorder, of an unrevoked, uncancelled "diploma regularly issued by a medical college properly and lawfully organized under the laws of the State wherein said college shall be located."

Arkansas.—A certificate of successful examination by the State (or a county) Board of Medical Examiners. Diplomas confer no right to practice.

California.—A certificate issued on the diploma of a college in good standing or upon a successful examination by one of the State Boards of Medical Examiners—regular, homeopathic or eclectic.

Colorado.—Similar to California, except that there is but one State Board of Medical Examiners.

Connecticut.—A certificate of registration of the diploma of a college "recognized as reputable by one of the chartered medical societies of the State," regular, homeopathic, eclectic; or a certificate of satisfactory examination by a committee appointed for the purpose by the State Board Health.

Delaware.—A certificate based upon the registration of a diploma from "a respectable medical college," or upon "a full and impartial examination by the State Board of Medical Examiners."

District of Columbia.—Nominally the indorsement of a diploma, or an examination, by a committee of the District Medical Society; practically no requirement.

Florida.—A certificate of satisfactory examination by the State (or a district) Board of Medical Examiners. Diplomas confer no right to practice.

Georgia.—The registration of a diploma from any "incorporated medical college, medical school or university." The clerks of the Superior Courts are the sole judges of the diploma as evidence of fitness for medical practice.

Idaho.—The record of a diploma at a county seat.

Illinois.—A certificate issued by the State Board of Health upon the diploma of a legally chartered medical institution in good standing as determined by the Board, or upon a satisfactory examination by the Board.

Indiana.—The registration, in a county clerk's office, of a diploma "from some reputable medical college."

Indian Territory.—*a.* Cherokee Nation: An examination by the Board of Medical Examiners; *d.* Choctaw Mation: A certificate by the Board of Medical Examines; *c.* Creek Nation: Payment of $25 annually as a license fee.

Iowa.—Similar to Illinois.

Kansas. — The registry of a diploma from "some respectable school of medicine," or of a certificate of qualification from some State or county medical society.

Kentucky.—A certificate from the State Board of Health issued upon the "diploma of a reputable and legally chartered medical college."

Louisiana.—The record of a diploma from "any medical institution of credit and respectability" after indorsement by the State Board of Health.

Maine. — No legal requirement. In 1887 an act to regulate the practice of medicine was passed by the Legislature but was vetoed by the Governor.

Maryland.—A certificate issued upon a satisfactory examination by the State Board of Medical Examiners. Diplomas confer no right to practice.

Massachusetts.—No legal requirement.

Minnesota.—Similar to Maryland.

Mississippi.—Similar to Maryland—except that the examination is made and the certificate issued by the State Board of Health.

Missouri.—Similar to Illinois.

Montana. — Ten years of practice; a certificate upon the diploma of a college "in good standing," or upon an examination by the State Board of Medical Examiners.

Nebraska.—A certificate issued by the State Board of Health upon the diploma of "a legally chartered medical school or college in good standing," as defined in Section 8 of the Act of July, 1891.

Nevada.—The record of a diploma from "some regularly chartered medical school."

New Hampshire. — No legal requirement.

New Jersey.—A license issued upon a successful examination by the State Board of Medical Examiners. Diplomas confer no right to practice.

New Mexico.—A certificate upon the diploma of a legally chartered medical institution in good standing, or an examination by the Territorial Board of Medical Examiners.

New York.—A license issued upon a successful examination by one of the State Boards of Medical Examiners—regular, homeopathic, eclectic. Diplomas confer no right to practice.

North Carolina.—A license issued upon a successful examination by the State Board of Medical Examiners. Diplomas confer no right to practice.

North Dakota.—Similar to North Carolina.

Ohio.—The diploma of a respectable school of medicine, or a certificate of qualification from a State or county medical society.

Oklahoma.—A license issued by the Superintendent of Public Health upon a medical diploma or after examination.

Oregon.—A certificate on the diploma of a college "in good standing," or after examination by the State Board of Medical Examiners.

Pennsylvania.—A license issued after examination before one of the State Boards of Medical Examiners: Act of May 18, 1893; takes effect March 1, 1894. Diplomas will thereafter confer no right to practice.

Rhode Island.—No legal requirement.

South Carolina.—A certificate of verification of the diploma of a reputable medical college. An Act of December 24, 1890, abolished the State Board of Medical Examiners created by the Act of 1888 and under which the diploma conferred no right to practice.

South Dakota.—A license issued by the State Board of Health after examination. Diplomas confer no right to practice.

Tennessee.—A license on the diploma of a college "in good standing," or after examination by the State Board of Medical Examiners.

Texas.—A license issued after examination by a District Board of Medical Examiners. Diplomas confer no right to practice.

Utah.—A license issued by the Territorial Board of Medical Examiners after examination. Diplomas confer no right to practice.

Vermont.—The registry of a diploma indorsed by one of the Boards of Medical Censors, or a certificate of examination by one of the Boards.

Virginia.—A license issued after examination by the State Board of Medical Examiners. Diplomas confer no right to practice.

Washington.—Similar to Virginia.

West Virginia.—A license on the diploma of a reputable college, or after examination by the State Board of Health.

Wisconsin.—The indorsement of a medical diploma by the censors of either of the State or County medical societies.

Wyoming.—The record of a diploma with a registrar of deeds.—*J. A. M. A.*

## A STUDY OF TRIONAL.

Dr. Beyer (*Archiv. fur Psychiatric*, Bd. XXV. Hft. 2), says:

Among the new hypnotics, trional, since its first therapeutic employment by Barth and Rumpel in the Hamburg Hospital and by Schultze in the Psychiatric clinic at Boon, has constantly gained ground in the estimation of the physicians, all of whom praise its hypnotic properties, although as yet undecided in regard to the more special questions as to its application. Supported by the numerous observations made for a long time at the Psychiatric Clinic of Strassbourg, including personal observations in sixty cases in the female division, it is now possible to sift the material collected up to this time in eight publications, so as to determine the special and general indications for the use of trional.

When administered in sufficient doses, trional almost always produces a feeling of sleepiness, which soon results in quiet, dreamless refreshing sleep. The full effect usually manifests itself in the course of half an hour. It is prevented by bodily pains, noises in the neighborhood, and even light—the same conditions which are also apt to interfere with normal sleep. Patients who have already fallen asleep are easily aroused by noises in the vicinity. Horvath attributes his bad results to the crowded state of his hospital wards at Buda Pesth. The duration of the sleep seems to depend, to a certain extent, upon the size of the dose, at any rate, it was found that while smaller doses act rapidly and effectively, the effects persist for only a few hours. After waking the patients feel refreshed, although the disease from which they suffer is not influenced by the hypnotic. If the dose is accurately estimated no after effects appear. The isolated observations of some authors that a single evening dose exerts an influence on the second night could not be confirmed in our cases of mental diseases. On the contrary, our experience like that of others has taught us, that discontinuance of the remedy, whether intentionally or in consequence of refusal of the patient to take it, or its secret replacement by some indifferent powder, or frequently diminution of the dose, had an unfavorable effect upon the sleep. A slight cumulative action such as has been noted among others by Raimondi and Mariottini seems, however, to exist. Frequently the first dose prescribed fails to act, while if repeated in increased quantity on the following evening it exerts its full effect, and during continued use of the remedy it was often possible to reduce the dose, provided that there was no change in the symptoms.

We can, therefore, coincide with Bries' suggestion to begin with a dose somewhat more than the medium size, and then soon to diminish it.

Habituatian to the remedy has not been observed thus far and we found ourselves necessitated to increase the dose only under certain circumstances, especially excitement, as for instance at the time of the menses. Its withdrawal after protracted use has never had any other consequences than return of nocturnal restlessness, if the patient did not regain normal sleep by reason of the occurrence of recovery.

Various authors have attempted to employ trional as a sedative remedy during the day, but the results have not been brilliant. Schultz obtained a moderatively satisfactory result only when instead of several small doses administered morning and evening he gave 2 grms, and Shaefer likewise failed to accomplish anything with 0.5 grm., given four times daily. Boettiger alone obtained good effects from this method, and demands further experiments with fractional doses. In view of what we have observed, although but in a few cases we would admonish against this method of administration.

Trional is a hypnotic and not a sedative. Small doses are ineffective, large ones induce sleep, or a desire for sleep, which is counteracted by day light, unquiet surroundings, etc., so that a very disagreeable condition results. As far as we can see, the good results in this direction have been obtained only in the case of paralytic or demented subjects who are oblivious to such disturbing influences.

As a sedative we therefore always prefer opium, and have found that its use in conjunction with that of trional affords excellent results, if opium is given thrice daily and trional in the evening. In cases where bodily pains interfered with sleep we observed similar success by combination with morphine, which alone would have had a sedative, but not hypnotic effect. When, however, the pains have been controlled by morphine and then trional was administered, a restful sleep ensued.

As regards disagreeable or injurious after effects, we have not noted these after prolonged use, but after employment of large doses and somewhat more frequently than most authors. If a patient after waking does not at once feel refreshed, but complains of drowsiness, a tired feeling of the eyes, etc., this serves as the first warning to us that the quantity of trional prescribed is too large. Furthermore, we observed in several instances marked drowsiness and very noticeable vertigo and staggering, similar to cerebral ataxia, symptoms which have been described by several authors. Actual symptoms of poisoning, such as severe malaise, cyanosis, vomiting gastric disturbances were seen by us in only two cases, in which trional was administered in several doses during the day, although the total daily dose did not exceed the customary limits. In two other cases slight after effects occurred while the drug was being administered in this manner, so that we are therefore inclined to assume that disturbances manifest themselves more readily after several fractional doses than after a single large dose. As a matter of fact, all the symptoms disappeared within a few hours after discontinuing the remedy and failed to return later if its administration was continued in the proper dose.

One of the main points in the administration of trional is the dosage. This explains in many cases the numerous contradictions in the different reports with reference to the inefficacy of the remedy on the one hand, and the unusual occurrence of after effects on the other. Above all, we would emphasize the radical difference in effect between males and females, which has nowhere been mentioned hitherto. If in one case the administration of even 1 gramme is followed by malaise and a staggering gait, while in another 3 grammes scarcely suffice to produce sleep, this circumstance is easily explained if we have to deal in the former cases with a young woman, in the other with a vigorous man. On an average male patients require at least 0.5 and at the most 1 gramme more than females. A second important element in the dosage is the constitution and bodily weight of the patient. After administration of as small a quantity as 0.5 to a hyphotic girl, whose weight was twenty kilo, we noted well marked vertigo. A third point is the nature of the insomnia or psychosis; aside from these factors a number of conditions must be considered which exert some influence if present for a time, even for a number of hours; these are psychical excitement, hallucinations,

menstruation, and the ingestion of food. For example at a time of especially violent excitement, a patient will require a large dose, 2 to 3 grammes, to obtain the full effect, without experiencing ill results therefrom, while later when at rest the same dose would produce disagreeable after effects. Besides this, the effective dose gives comparative little latitude, and quite closely approaches the dangerous limit.

For all these reasons we cannot agree with previous observers who let the dose range from 0.5–3 grammes, fixing the latter as the upper limit. It must again be emphasized that trional demands a dosage accurately regulated according to the sex, constitution, bodily weight, the nature of the disease, and the presence of temporary symptoms, the dose being subject to daily revision if possible. It is frequently advisable to determine the quantity to be used in the evening just before its administration, which is perfectly feasible on account of the rapidity of the effect, and preferable to giving a second dose later in the night. A well estimated single dose in the evening assures almost without exception a good effect.

It remains to consider the main indications governing the employment of trional. Its action is almost absolutely certain in simple insomnia and also in cases of neurasthenia, the initial dose for males being 1 to 1.5 grms., for females 1 grm. and later reduced to 0.5 gms. Similar brilliant results may be obtained in simple melancholia from the same doses, especially in the above mentioned combination with opium. Larger doses are required in mania, but have equally good effects; 3 grammes may be administered to males, 2 grammes to females, the large doses during attacks of especially marked excitement, the smaller during their subsidence, while during the period of convalesence, they may be reduced to 0.5 grm. Trional has a remarkably favorable action upon the hallucinations both in the acute forms as well as in chronic paranoia. The patients, often to their own surprise, slept quietly and undisturbed, even after administration of medium doses 1 to 2 grammes. In delirium tremens, if the dose is accurately estimated, the effect seems always to be developed. In the other psychosis we have not as yet obtained results which would warrant positive conclusions, and the numerous cases in the literature furnish no uniform data, especially since the above mentioned points are not sufficiently noted in reporting the results. Further observations, which should be as specific as possible will be necessary to explain the still uncertain indications for the use of the remedy in paralysis, morphinism, etc.

This much is well established, that trional although devoid of useful sedative properties, may be warmly recommended as an excellent hypnotic; in small doses in simple and neurasthenic insomina, in combinations with morphine in cases of bodily pains, in combination with opium in melancholia, in medium doses in cases of hallucinations, in larger ones in mania. The drug has no specific influence upon the psychosis. The effective dose varies according to the individual and the symptoms, ranging from 0.5 to 4 grammes.

It closely approaches the limits of dangerous effects which sometimes manifest themselves after small doses down to 1 gramme, so that a generally applicable maximum dose cannot be designated. We are even the less inclined to fix the maximum daily dose, since it is our custom to administer trional only once pro die and in the evening. Injurious after effects can be easily avoided and rapidly and completely disappear as soon as the remedy is discontinued. Permanent ill results have not up to this time been observed.

---

MR. SUMMERBOARD—"What are you going to do now?"

Mr. J. Hay Seed—"Jist a settin' this hen."

Mr. Summerboard—While you are about it couldn't you set the rooster, too?"

Mr. J. Hayseed—"Set th' rooster! If that ain't a good one! W'y—"

Mr. Summerboard—"As I was saying, could you not set him for about six in the morning I am tired of being awakened at daybreak."—*Lowell Vox Populi.*"

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AN illustration of the severity of the times is found in the fact that two London physicians lately advertised in a daily paper, offering $5,000 to a man who would submit to an experimental surgical operation involving some risk. One hundred and forty-two answers were received.

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The Columbian postage stamps may not be the greatest works of art, but they are pretty hard to lick.

# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*January 19, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### MICROCEPHALUS — PROPRIETY OF OPERATION.

DR. A. M. VANCE: I asked this lady to bring her baby here this evening to show a typical case of arrest of development of the brain—microcephalic condition—and to bring up the question of an operation which I performed once or twice in this city. This case seems to me to be a typical one of the class which have been operated upon formerly even more than at the present time. I have recently come to the conclusion, more particularly from reading and also from my experience, that craniectomy for microcephalus is an unjustifiable operation, and I have so informed this mother. This child has practically no mind, and is also paralytic. In talking with Dr. J. F. Barbour, who receives a great many foreign exchanges, he told me of a report by some French surgeon who for years has had charge of one of the largest foundling asylums in the city of Paris, who reports eighty-three cases correlated by him and in this report he draws the conclusion that in no case did good result from the operation. In the case I reported some time ago, and also made a continued report,—the patient was about the age of the one before us,—there has certainly been no material improvement from the operation. I opened both sides of the head, allowing a period of several months to elapse between the operations and while the child had no trouble from the surgical procedure, there has been practically no improvement in the condition after almost a year. I would like to hear an expression from the fellows on this subject. The Frenchman I have referred to states that it is entirely a mistake to suppose early ossification is the causative agent in lack of development of the mental faculties; that the brain ceases to grow, and early ossification takes place owing to the arrest of development of the brain substance.

#### DISCUSSION.

DR. J. M. RAY: I have nothing to say regarding the surgical procedure, but I would like to see an ophthalmoscopical examination made of the eye.

DR. A. M. CARTLEDGE: I do not think from what I have read, and what Dr. Vance, who has had considerable experience with this class of surgery, says, that the results justify an operation.

DR. TURNER ANDERSON: I do not see what could be accomplished by an operation in this case. It is the first typical microcephalic child that I have ever seen.

DR. E. R. PALMER: How long has this child been going to see a doctor, and has there been any discharge from the nostrils?

DR. A. M. VANCE: The mother dates the trouble back to an attack of pneumonia lasting for three weeks when the child was about a month old. There was some catarrhal trouble at that time which was attributed to the attack of pneumonia.

DR. WM. BAILEY: Cases like the one before us have generally been regarded as utterly hopeless. I was delighted at the prospect that was offered to the profession in the claims made by those who were operating according to the method Dr. Vance has spoken of, that some good might possibly come to these hitherto hopeless cases. I do not think it has been determined what is the pathological condition here, whether the arrest of brain development is dependent upon consolidation of the cranium and want of development there. I think that it is noticed that the cranium closes sooner in these cases and more firmly; then, again, that there seems to be a failure of development of the brain, so it is a question in my mind whether the trouble is early ossification, or whether a failure of brain development precedes that condition, dependent upon something else that we do not know. I was hopeful when operation was first proposed and reports made by those operating, that improvement would follow. I can readily see how by opening the skull, giving the brain additional room, that temporary improvement would come, and I believe this is the history of some of the cases—that the muscular spasms, that the irritation apparently is diminished for the time being, but I am sorry to learn that there is no better outlook for the operation.

DR. T. S. BULLOCK: Like Dr. Cartledge the only knowledge I have of these cases is from reading, and from this I have come to the conclusion that operative procedure is unjustifiable, and I question very much

whether there is any betterment of symptoms even of a temporary character.

DR. W. L. RODMAN: I, like the other gentleman, who have spoken except Dr. Vance, have never done a linear craniotomy, but I have had several opportunities to do it; in fact, I was called to see this case three months ago, having been asked to see it by Dr. Woody, and declined to operate, I do not see that there is anything to be gained by an operation, and have never believed in it. I have seen it done several times and have been so situated that I was able to follow the history of a number of cases that had been operated upon by Keen and others at Philadelphia. The result in these cases was such as not to encourage me to operate. Two years ago this month I visited Dr. Kerlin, who was then Superintedent of the largest Feeble Minded Institute in the United States, which you know is at Elwyn, Penn. He talked a great deal about the operation. He told me that a number of children in the Institution had been operated upon by Keen and others without improvement. Keen has done more work in this line than any other surgeon in this country or anywhere else, except Lanilangue, who first performed the operation. It is a dangerous procedure as we all recognize, a fair proportion of the patients dying on the table. In view of the fact that it is such a dangerous procedure, and that results have not been as good as we might have expected, I believe the operation is one which will very speedily fall into disuse. It seems to me that it is not based upon good patholooy and I believe the operation has no place in the surgery of the future.

DR. J. A. LARRABEE: This is the fourth case of microcephalus I have seen recently, and I believe this child is in better condition than any of the others. The last one seen was in New Albany, Ind., a child probably two or three months older than the one before us; head measurement 15 inches, while this one measures 16 inches. While in the other cases the attention could not be drawn to anything this child sees without doubt and is attracted by distant objects. The palatine arch in this case is not nearly so high as in many other cases. The vaulted arch of the palate which lessens the capacity of the cranium is much better in this case than in the three others I have alluded to.

In regard to the matter of obtaining relief by craniotomy or by division giving the brain more room: I believe that operation is adapted to some cases where we have a condition opposite to this, and that is of hypertrophy of the brain, by which I mean an increase of the white fibrous tissue crowding out the gray matter of the brain so that it cannot be deposited. I believe in such a case as this benefit might be expected from an operation. But in a microcephalic skull like the case before us, it has simply adapted itself to the brain and I fail to see the necessity for an operation. In the other class of cases the child is forever trying to break its own skull. I have seen cases of this kind where they have endeavored to strike the head to obtain relief; it would seem that if we could take a mallet and break the skull as we would break a cocoanut, it would afford the proper relief. In hypertrophy of the brain, when the skull is divided in *post mortem* examinations the convolutions are found so flattened, the brain is so pressed that you cannot introduce a small instrument between the folds. It seems to me that there is an indication for craniectomy in such a case, and we might hope for relief by it, but as I have already intimated I do not see what hope we have for relief by operation in the opposite condition, like the case before us. From my experience and observation with several of these cases, I believe the best results are obtained by putting such children in a Feeble Minded Institution, where they may be properly cared for. In such an institution some development takes place, and in the case before us I should have more hope by that method of treatment than anything else.

DR. E. R. PALMER: There is one question I neglected to ask, and that is whether this mother ever had a miscarriage?

DR. A. M. VANCE: She has had one miscarriage at the fourth month, and preceding the birth of this child.

DR. C. W. KELLY: I can only voice the opinion expressed by Dr. Bailey so far as closure of the skull upon the brain is concerned; first that there is arrest of brain development, then closure of the sutures. It is evident that there is arrest of development of the brain otherwise there would not be closure of the fontanelle and sutures. If that be true an operation would necessarily not be warranted or justified; certainly I can see no future for operation upon cases of this character.

DR. W. C. DUGAN (Visiting): I have had no experience in this class of work; I have assisted Dr. Vance in one operation, but had no opportunity of following the case to see what the result was. Dr. Cantrell, of Salt Lake City, Utah, some time ago sent me several photographs of a patient he had operated upon by the method Dr. Vance has mentioned. This patient had spastic paralysis of one side. Before the operation there was no intelligence, whatever, but there was certainly great improvement after the operation. However, not enough time had elapsed to justify him in coming to any conclusion, but certainly the spastic hemiplegia was entirely relieved by the operation.

DR. E. R. PALMER: There is a man in this city whom I knew as a boy, and I knew him to be in active syphilis when he married; if he has not a child which is an absolute mate to the one presented here to-night, I never saw two cases of disease that looked alike. The child is now about three year old, and is carried about by its grandfather; it has the same convulsive movements the same strabismic condition, the same characteristic Hutchinson's teeth. The mother gives the history of a miscarriage at four months, just as in the case before us to-night. It is a very common thing for people who live a few miles in the country to come in town and in their "lark" as they call it, contract a case of syphilis, go back home and have some such result follow as we see in this case and also in the case of the clerk I have mentioned. The father of the child presented to-night lived within a few miles of Asheville; of course there is nothing personal in these remarks. The child seems to be well nourished. It has not the characteristic fingers of hereditary syphilis, but it certainly has notched teeth which, however, might occur from ordinary malnutrition; but it is strikingly like the child of the clerk I have spoken of whom I knew to be in active syphilis with early secondary eruption out when he married, and his wife so far as her general appearance goes, is absolutely devoid of any syphilitic manifestations.

If an operation is advisable it would be that the public might be relieved of the care of a child which is unquestionably an incurable idot.

DR. A. M. VANCE: I have very little to say further. It is a subject that ought to be discussed because these children are being operated upon every day, and I do not believe the literature of the subject will bear us out. I believe it is about seven years since the first operation was done and this French surgeon has collated eighty-three cases; he is a man evidently of large experience having had charge of the largest Foundling Asylum in Paris for twenty years, and he states that no benefit is derived from operation. He also makes the statement that he is convinced from his operations, that in many of these cases it is not primarily a bone trouble but it is arrest of development of the brain and ossification takes place as a consequence.

I do not think the history of this case points to syphilis as the cause. I have never heard it brought up before. The fact that this is a microcephalic child does not prove that there is a specific element in the family; on the other hand there is absolutely no history of syphilis on either side.

I do not think I will ever do another operation for a condition of this kind, as I believe it is unjustfiable.

DR. D. T. SMITH: First in regard to Dr. Palmer's position that this is syphilis. That the child may have syphilis of course I am not prepared to deny, but that syphilis can perpetuate or produce microcephalus, or that syphilis has any relation to microcephalus, I am not at all prepared to believe.

As to operation: I agree with Dr. Vance that we have reached the position where we all know that operation promises nothing except that it might to a certain extent eliminate from society this troublesome element.

In reference to the conclusions arrived at by the French surgeon, as quoted by Dr. Vance, who claims that there is an arrest of growth or development of the brain, which causes an arrest of the skull and consequent ossification. It seems to me it would be a very hard thing to prove that such a condition occurs. We know very well that through the entire course of animal evolution, there is a correlation between the growth of all parts. Who ever heard of the bones outgrowing the muscles of the arms, for instance, or the arteries or nerves being to short. The forces are so balanced that whatever causes arrest in development of one, similarly affect the other; so I take it where there is arrest of the brain there must necessarily be an arrest of the skull from the same cause, and vice versa.

DR. T. L. MCDERMOTT: I take it that this condition of affairs may be due to some faulty development of the ovum; for instance in a family of eight children, you will usually find seven robust children and one microcephalic child. You will find a history of a miscarriage connected with it, in which there has been defective development of the ovum, and this may have some bearing upon the case.

DR. J. A. LARRABEE: I am as fond of attributing disease to syphilis as any body can be, and I think I have rivaled my friend Prof. Palmer in attributing many things to syphilis; in fact I am very willing to refer a great many of the ills of the human family to this disease, but I think in this we have a case where the doctor draws too broad conclusions from too narrow premises. We are impressed by the rarity of microcephalic children at least in this country; we are also impressed with the multiplicity of cases of syphilis. There are several points in Dr. Palmer's relation of the cases that I want to call attention to. First he emphasizes the fact that the mother of the clerk's child was entirely free, and has been throughout, from any syphilitic manifestations, yet she gave birth to a child giving every evidence of inherited syphilis. I would like to ask Dr. Palmer how this mother could give birth to a syphilitic child and be entirely free from

the disease herself. Second, if this be true then Dr. Palmer must grant that infection of the ovum took place through the male, without contamination of the mother. Does he so grant?

DR. E. R. PALMER: It is a settled matter that many people are practically immune from syphilis. In reply to the second question, authorities differ, but my own belief which is the one most generally held by syphilographers is that a syphilitic baby has a syphilitic mother. However, many syphilitics in early stages present few or no evidences of the disease and that too where no treatment is instituted.*

DR. J. A. LARRABEE: Another point: Emphasis was placed upon the question of serrated teeth, which is a condition of absolutely no importance in deciduous teeth. Characteristic Hutchinson's teeth are furrowed, notched or grooved, and without enamel; but this condition must exist in the permanent teeth to be of value as a diagnostic point. This mother stated that the child was unable to nurse for three days; it is a well known fact that a child suffering with acute pneumonia cannot nurse, so that this fact has no practical bearing upon the question of syphilis. If the child had had obstructed nostrils at birth and that condition had continued for six or eight weeks, that would be an unmistakable evidence of syphilis, but no such history can be elicited. We have not asked this mother what influences were brought to bear upon her individually. It is a recorded fact that during and immediately after the siege of Paris, microcephalic and idiotic children were born in such numbers that all the asylums were filled. An investigation proved this to be due to the maternal impressions received during the insurrection. This mother has not been interrogated as to what maternal impressions may have been received during the time she was carrying this child.

From our present knowledge of the disease I think the effect of syphilis upon the brain is to increase the growth of the packing or white fibrous tissue, and we would be more liable as a result to have an opposite condition of the head from microcephalus, we would get hypertrophy. I believe this is the position taken by all authorities upon the question of syphilis, but I have never heard it intimated before that microcephalus might be the outcome of syphilis.

* Bergh states (*Hospitalstidende*, 1893, p. 697) that, while it is generally acknowleged that syphilis may be inherited as well from the father as from the mother, it has been doubted that the child may inherit from the father while the mother remains in perfect health without syphilitic taint. Bergh has observed a case which appears to prove the possibility of this condition.

A young prostitute who never had suffered from syphilis was delivered of a female child, who, three weeks after birth, presented evident symptoms of hereditary syphilis (erythema syphil., ulcers in the anal region, coryza). The symptoms disappeared after treatment with calomel. More than six months after the birth of the child the mother came under treatment for recently-acquired syphilis, with indurated chancre, enlargement of the inguinal glands, etc. The child had been reared under circumstances in which it was not likely to acquire the disease, the symptoms being those of inherited, not acquired syphilis; and the fact that six months later the mother was taken ill with the primary symptoms seems to prove that she must have been healthy at the time of childbirth.—ED.

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**Milk as Drink.**

Milk is an important food and should not be taken as a drink simply. If eaten as the Persians use it, holding it in the mouth until it is thoroughly combined with the saliva to aid in its digestion, as a part of the meal it is all right, taking the place of other food. It requires digestion as necessary as any other food, but, that it may digest, it is first formed into a solid mass—"curd," and is then acted upon like other solids. Unlike water, which requires no digestion, as a drink, it cannot take the place of our special drink between the meals without much taxing the organs of digestion. This principle is well illustrated by the fact that the nursing infant cannot take its food rapidly, as it must pass through many small orifices, sieve-like, the drawing process exciting the flow of the saliva, aiding in the digestion of the milk and the nourishment of the babe. I repeat, emphatically, that it is food, and not a proper drink.

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IF we would take sufficient time for our meals, chewing our food as much as the circumstances really require, taking as much pains in this matter as the smoker does to light his filthy pipe—worse than wasting time in smoking it—we would have much better digestion, with abundance of time for all real duties. We shall all have time for our meals and for sleep, if we waste no time in useless amusements, or anything not required by actual duty, engaging only in such pursuits as will promote our health and happiness.

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PROFESSOR—How long should a man's legs be in proportion to his body? Mr. Lowstand—Long enough to reach to the ground, sir.—*Yale Record.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

for March. Dr. Andrew J. McCosh contributes the

**Report of Four Cases of Brain Surgery.**

The author confesses that the recent advances in the localization of brain functions have not added to the success in treatment of epilepsy by operative measures and states that the results obtained, so far as cure is concerned, are but little better than those obtained a score or more years ago. While it is true that certain cases of Jacksonian epilepsy have been cured permanently by operation, yet we must acknowledge that operations for the cure of true idiopathic epilepsy have been discouraging. The author believes that most of our accurate knowledge must be derived from the observations of the pathologist and and surgeon, as experimentation on animals has thrown but little light upon the matter. The first case reported by the author is one of extra-dural hemorrhage with convulsions, in a lad of eighteen years, the result of a fall received the night before his admission to the hospital. At the operation the surface of the dura matter under the clot was found roughened, but was not lacerated or apparently injured in any way. It was not opened. No additional clot or sign of fracture could be discovered. The patient had a slight convulsion, limited to the right hand and leg, shortly after the operation; but no further sign of cerebral irritation showed itself and the patient made a rapid and uneventful convalescence. He has been perfectly well ever since, earns his living as a bricklayer, and does not hesitate to go on an occasional spree.

The second case occurred in a boy of six years suffering from extra-dural hemorrhage with convulsions and paralysis, the result of a fall down stairs when he is supposed to have struck his head. On the seventh day after injury he began to have convulsions and the operation was performed on the eighth day. On the fourth day after operation there was a discharge of broken-down brain tissue from the drainage tube and a tendency to hernia cerebri. This however, had ceased on the seventh day and the paralysis of motion and sensation had almost disappeared. At the end of two weeks the boy was out of bed, without sign of paralysis. He has been in good health ever since; he has attended school, is bright at his lessons, and entirely free from pain, convulsive movements, or paralysis of either sensation or motion.

The third case is one of drainage of the lateral ventricle in a man of twenty-nine years, florist by trade, who gave a history of occasional attacks of unconsciousness ever since he was twelve years of age. The author states that the patient, at the expiration of eleven and a half months from the time of operation, continues bright and intelligent, and no convulsions have occurred. He has no headache or tenderness of the cicatrix. His memory is good. He has been intoxicated more than once without bad consequences.

The last case was one of epilepsy in a girl of six and a half years in which there existed a sub-dural organized clot. The child recovered quickly from the operation and showed very little shock. For three weeks following there was no special change for the worse or better. The convulsions continued as before, as did the paralysis. Five months after the operation the child had gained in weight and appeared brighter, but the convulsions had not been modified by the operation; they occurred as frequently and their character had not changed. A slight improvement in the paralysis had, however, taken place. Under the date of January 16, 1894, the author notes "during the past four months the progress of the case has been most interesting. In the beginning of October the convulsions became more frequent, averaging from twelve to eighteen in the twenty-four hours. The patient was again admitted to the hospital for the purpose of inserting gold foil between the dura and the brain. The child, however, had slight fever, and in a few days it was evident that she had typhoid fever. The case was rather severe and protracted. The remarkable fact about it was, however, that from the time the disease was well established, not a single convulsion occurred. The child has now been well for about two months, and during this time she has been entirely free from any convulsive movements. She has grown considerably, and the partially atrophied muscles of her right arm and leg seem to be fuller and stronger, though a certain amount of paralysis still persists."

The author states that he has trephined three other patients for epilepsy within the last few months. All have recovered from the operation, though it is too soon to speak on the results. The mere removal of a button of bone from the skull seems to improve nearly all epileptics for a few months, and it is rather misleading to report on the condition of these patients before sufficient time has elapsed for the disappearance of the amelioration which may be attributed to the operation *per se.*

The paper is illustrated with diagrams showing the position of the trephine wounds.

Dr. Herbert Snow, of London, Eng. contributes a paper on

**The Early Diagnosis and Practical Surgery of Cancer.**

He says, "With the exception of a numerically small congenital group of tumors, which he has classified under a special term, *Blastoma*, and which mostly differ from ordinary cancer in arising spontaneously, malignant new-growths are almost entirely restricted to women above the age of thirty-four, to men past forty. Further, they appear in organs which have fulfilled their func-

tional purpose and are undergoing devolution, as now effete appendages, *e. g.*, the sexual organs of women; or else in tissues whose vitality has become conspicuously impaired, such as the buccal mucous tract of men. Hence we are bound to look with grave suspicion upon any incipient tumor-formation in these parts of the respective sexes; in people growing old; in those whose general health and energies have, from any cause, become markedly undermined." The two items which most prominently demand attention are first, the age of the patient; and secondly the history of the case. In the female mamma, the age of thirty-eight years forms a rough limit, which the author has often found of great practical use. Under that period, there is much probability in favor of the non-malignancy of any doubtful "lump." It may be laid down as a practical axiom, too, that no average species of malignant tumor in the adult ever appears without an adequate and generally ascertainable exciting cause. The patient often gives a history of hard toil, privation, or of especially laborious occupation. Among the last named, laundry work, in the author's experience, stands pre-eminent. When a middle-aged woman comes to the Cancer Hospital with a breast tumor, and says she has been a laundress, he has learned to regard the growth as almost certainly malignant. The author reiterates the statement so oftened made that persistent and early uterine hemorrhage in a woman, who from her age may be regarded as predisposed to cancer, should always induce a prompt local examination. In men, a very considerable proportion show marks of antecedent syphilis; others are alcoholic individuals, who also smoke, both of which practices directly deteriorate the epithelium. Men of the laboring class rarely pay the attention which women do to cleanliness. The mouth in particular is commonly foul, and decayed tooth-stumps are seldom interfered with; hence the natural sequence of epithelial cancer, almost invariably the manifest result of neglect. An enlarged lymph gland in the neck, axilla, or groin occuring in a man of forty, not associated with an obviously septic cause in the vicinity (e. g., suppuration, syphilis, diphtheria) and following no mechanical injury, will almost certainly prove to be an incipient cancer, yet the author states that he has seldom met with one of these distressing cases in which the gland had not been painted for weeks or months with iodine. As an example of the evil results of delay and the reliance of upon certain microscopical indications of no more than merely negative value, the author refers to the case of the late Emperor Federick of Germany. The author is of the opinion that the microscope for diagnostic purposes is of doubtful use.

It is of vital importance always, in the surgical excision of these lesions, at the same time to remove thoroughly all of the dangerous lymph glands in the "infection path;" and this, if possible *before enlargement has been suffered to take place.* In the proper working out of this maxim, combined with early diagnosis, lies all the best hopes of improvement in the cancer-surgery of the future.

Nothing is more pernicious than the custom of witholding opium from the average patient until he or she is worn out with pain. Opium, persistently given from the earliest moment at which there is reason to believe the disease incurable by surgical means, not only materially prolongs the individual's life, but it has often a most marked influence in arresting the progress of the growth. A carcinomatous breast thus dealt with, previously to the stage of ulceration, may often be successfully diverted from a rapidly advancing tumor into that withered "atrophic" induration which permits many years of fairly enjoyable life. With this should be enjoined as passive and vegetative a mode of existence as possible; and to such, careful nursing will materially conduce. Cocaine-hydrochlorate internally administered is a useful adjunct to the opiate treatment. Its advantages are best seen in malignant disorders of the alimentary canal. Iron, arsenic, quinine, tonics in general are useless except as placebos.

Dr. Robert P. Harris presents an account of

**A Double Ovariectomy, Performed Fifty Years Ago,**

by the late Dr. John L. Atlee, of Lancaster, Pennsylvania, upon a lady who is still living and in excellent health. The case has several features of note, viz.: 1. The patient has lived longer after an ovarian exsection than any subject whose case is on record. 2. As far as can be ascertained, she is the first from whom two ovarian tumors were exsected at one operation, in any part of the world. And 3. She was the first subject on which the late Dr. John L. Atlee performed an ovariectomy, out of his list of eighty cases, covering a period of forty years. The reporter takes exception to the term "ovariotomy," which does not express excision or extirpation, and prefers the term "ovariectomy," used in the same sense as "hysterectomy" or "nephrectomy," as the more correct. The report of the operation appeared in *The American Journal of Medical Sciences*, for January, 1844, and is embodied in Dr. Harris' account. The five ligatures used in the operation, having one end cut off near the knot—as was then the custom in amputations and extirpations—were brought out at the lower angle of the wound and secured, and the abdominal cavity was cleansed by sponging. The wound was now closed by seven sewing needles inserted at intervals of an inch, and wound in the figure of 8 form with silk, as in the hair-lip suture, strips of adhesive plaster being placed between them for additional security. The lady made a good recovery, and was only bled once, which was to the extent of ten fluid ounces, eleven hours after the operation, when her pulse rose to 136, but it fell to 120 after the venesection. The patient was remarkably well by the tenth day, with a clean tongue, sleeping well, able to sit up, and to walk several times across her room. Three weeks after the operation, she took a ride of two

miles, and two days later, of five or six miles; and on this date the doctor ceased his regular attendance. The operation was performed without either and lasted forty-five minutes. As the patient was alive to every sensation, she particularly refers to the process of breaking up the adhesions of the right tumor, which she says were five, and the separation of which caused an indescribable measure of suffering. In her after-treatment, she says she had a doctor, or a student of medicine with her, night and day for several weeks, and think they felt her pulse every half hour. She remembers being permitted to walk once across her room at the completion of two weeks; and taking a ride of two miles, a week later. She has led a busy life for half a century, and is described as still "active and sprightly."

In his report, Dr. Harris reviews the history of ovariotomy and presents a table of completed "ovariectomies" prior to that of June 29, 1843, together with a short sketch of the life of Dr. John L. Atlee.

The remaining papers in this issue are: "A Contribution to our Knowledge of Epidemic Cerebro-Spinæ Meningitis," by Simon Flexner, M. D., and Lewellys F. Barker, M. B. (Concluded).

"The Times and Modes of the Introduction of the Exotic Diseases of Children into America," by J. Lewis Smith, M. D.

"A Case of Leukæmia, with rare Lymphoid Growths of Orbits and Parotid Glands," by Thos. D. Dunn, M. D.

"Neuralgia of the Right Cranial Nerve of Sixteen Years' Duration; Excision of the Three Divisions at the Gasserian Ganglion; Death," by J. T. Eskridge, M. D., and E. J. Baker, M. D.

"Comparative Vitality of Men and Women," by Brandeth Symonds, A. M., M. D.

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IN THE BRITISH JOURNAL OF DERMATOLOGY for March appears an article by Dr. Edward Ehlers on

**Leprosy in Iceland.**

The author states that until the last few years it was believed that leprosy had been gradually diminishing, in consequence of government efforts to exterminate it, and was only to be found in Norway, Iceland, and a few other countries.

Owing to its long incubation, it was supposed that most cases occurring outside these regions had been contracted during previous travel.

Some sporadic cases occasionally seem to occur, but the diagnosis has always been received with doubt. One or two cases were called leprous trophoneurosis, and were supposed to differ from the old type of leprosy as modern syphilis does from the ancient form.

Zambaco Pasha now declares the diseases known as syringmyelia and Morvan's disease, to be nothing more than leprosy—the new terms arising from defective diagnosis, and he apparently proves his points. He goes even farther and declares scleroderma, sclerodactylia, ainhum, morphœa, and local asphyxia with symmetrical gangrene, to be consecutive stages and abortive forms. The author is not unwilling to concede ainhum as a possible form of leprosy, but does not think scleroderma and sclerodactylia can possibly be. He states that a large and flourishing leper colony exists in Iceland, and proposes an expedition to it to obtain proof, negative or positive. The paper will be continued in the next issue of the journal.

Dr. Wm. Anderson reports two cases of

**Morphœa;**

one in a married woman of forty-two years, in whom nothing abnormal was found after excision of the skin, and the latter showing no great microscopic changes—even the induration had disappeared almost completely after excision. In the other case the skin over the mammary gland was affected in a woman of seventy-two years. The thickened part was slightly purplish and over (but in all points separated by a layer of fat from) a scirrhus of the breast. The axillary glands were enlarged and the arm œdematous. In this case, again, the microscopic examination threw little light on the affection.

The same author reports a case of gangrenous cellulitis of the leg. A stoker, forty-two years old, suffering from gangrene of the skin on the dorsum of the foot, exposing the extensor tendons, and with inflammation as high as the patella, the skin discolored and separated from the subjacent tissues by sanious pus. The patient gave a history of the fall of a piece of iron on the foot three weeks before, and followed in two days by inflammation.

Sloughs and gangrenous skin were removed, a number of incisions made for drainage, a hot boracic acid injection made and the limb washed in bichloride solution 1 to 2000. A dressing of lint with chlorinated soda solution was used, and steady improvement took place. Skin grafts were successfully used to complete the skin reproduction.

The author thinks the case a rare one and that the condition was akin to the gangrenous erysipelas of former times.

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**Migranine.**

Under this name Overlach discribes the properties of a combination of antipyrine with caffeine and citric acid. He considers it a chemical combination of the three substances and after five years experience of its action in cases of migraine and other forms of headache, he has come to regard it as an almost infallible cure, even in the most obstinate cases. It is useful whether given in the premonitory stage or after the headache has fully developed and it is seldom that more than one dose is required. The dose is 1.1 gm. to be dissolved in water. This quantity contains only 0.09 grs. of caffeine or one-sixth of the maximal dose of this substance. It is recommended that the patient rest awhile after taking the drug, especially in cases of severe migraine.—*Deutche Med. Woch.*

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### The Treatment of Erysipelas with Pilocarpine.

The credit for the recommendation of pilocarpine hypodermically, in the treatment of erysipelas belongs to Prof. Da Costa. It is the custom of the author to inject daily one-sixth of a grain of pilocarpine, and in order to maintain the physiologic effects of the drug, to administer besides from fifteen to thirty minims of the fluid extract of pilocarpine thrice daily. Under this treatment, the temperature, as a rule, soon declines and the exanthm speedily disappears. This treatment is applicable in properly selected cases. The manner in which the drug acts is not known. —A. Ashner in *Coll. Clin. Record.*

### Indications for Treatment of Angina Pectoris.

Dr. J. Burney Yeo, summarizes the treatment of angina pectoris, as follows:

1. To maintain or improve, when defective, the general nutrition; to avoid all strain, physical and emotional, and to relieve cardiac feebleness and excessive effort.
2. To relieve dyspeptic conditions and flatulent or fecal distentions of the stomach and intestines.
3. To forbid the habitual consumption of agents which may exercise a tonic action on the heart, such as tea, coffee, alcohol, tobacco, etc., or that which may introduce or develop toxines in the alimentary canal.
5. To avoid and remove all gouty and other blood contaminations.
5. To give such tonic remedies as may improve the cardiac tone and lessen existing tendency to cardio-vascular degeneration.
6. To relieve the paroxysmal attacks by sedatives and stimulants.—*Boston Med. and Surg. Journal.*

### Burns.

The most exquisitely painful burns are assuaged in a few moments by an application of cocainized campho-phenique, after the following formula.

℞ Cocaine in hydrochlorate.....grv.
Campho phenique
Olive oil.....āā ℥ss

M.—Rub up the cocaine and campho-phenique, and add the olive oil.

A man whose hand had been torn and badly burned by an electric discharge, the pain of which was so severe, that he fainted twice before the dressing could be applied, expressed himself as absolutely without pain in less than one minute after the application.—*Med. Review.*

### Guaiacol as an Antipyretic.

Gualacol has been, and as is well known as a substitute for creasote in a large number of cases of pulmonary disease, where that drug was indicated, and so far as we know, has given so much satisfaction that it bids fair to supplant creasote in the treatment of many of these affections. Within the past few months the profession has begun to recognize the fact that it possesses other powers than those of an expectorant and antiseptic, or stimulant of the mucous membrane, and a number of prominent physicians have employed it for the reduction of high temperature.

Two of the most notable contributions which have been made upon this subject—the clinical lecture of J. M. DaCosta, and the interesting paper of Rabillard—are particularly worthy of note. In both these instances these clinicians used the drug externally upon the skin of the thigh, abdomen or chest, either by means of rubbing, or by painting it on with a camel's hair brush. After it was applied to the skin it was thought advisable in some cases to place an impermiable dressing over it in order to prevent evaporation. As a result of the application of 20—50 minims of guaiacal in this manner, it has been found that the temperature of malarial fever, typhoid fever and pneumonia rapidly falls as much as seven degrees in the course of an hour or two. DaCosta asserts that this rapid reduction of temperature is not accompanied by any marked disturbance of the nervous system, or any evidence of collapse, not even by a very profuse sweat; neither does there appear to be a very active chill, although sometimes slight dullness is experienced. The drug does not seem capable of holding the temperature down for any length of time, but it has been found perfectly safe to employ it as often in the twenty-four hours as is necessary to prevent pyrexia appearing with severity. DaCosta suggested that in many cases it may take the place of the cold bath as far as the reduction of the fever is concerned; but whether or not guaiacol on further use proves to be a valuable antipyretic, we are sure that the therapeutic results obtained by the cold bath cannot be substituted by this means of treatment since the cold bath undoubtedly exercises a therapeutic effect over and above that exercised by guaiacol. We do not wish to be understood as stating that Dr. Da Costa believes that the cold bath should not be retained. He simply suggests that guaiacal be employed in its place, when because of the lack of attendance, the bath treatment cannot be carried out, and because he believes that guaiacol is preferable to the antipyretics derived from coal tar in the reduction of temperature. In the treatment of hectic fever of tuberculosis J. Solis Cohen and others

have found this drug of equal value. It may be painted on the chest in the area occupied by the pulmonary disease, but it is said to be contra-indicated in cases in which there are hemorrhage or well-developed cavities.—*The Therapeutic Gazette.*

## SURGERY.

### Chloride of Ammonium in Cystitis.

Dr. G. Carrie, of Blossom Hill, Va., states that he has had excellent results from pulverized purified ammonium chloride, taken three or four times in the twenty-four hours, preferable when the stomach is somewhat empty, each dose to be followed immediately by a half globlet or a globlet of pure cold water. In the following condition the drug has given most satisfactory results in every instance: Cystitis dependent upon stone in the bladder; stricture; hypertrophy of the prostate; deposits of urates, etc.; gonorrhœa, both male and female; cystic irritation from uterine diseases or menstrual disorders; malarial effects; masturbation; early pregnancy; simple urethritis (traumatic) in newly married women; cystic and renal sequelæ of *la grippe*. In the majority of cases it was simply surprising to note the rapidity with which the urine was cleared of bladder mucus, blood-corpuscles, pus-corpuscles, urates, phosphates, etc., the distressing symptoms disappearing therewith; and in no case did the salt occasion any gastric or other disturbance, when taken as ordered.—*Virginia Medical Monthly.*

### A Means of Lessening Pruritus in Cases of Urticaria.

Dr. C. Pacaud (Sillans) has observed that the intense pruritus of urticaria, in children as well as adults, subsides almost instantaneously under the application of lemon-juice. As lemons are to be found everywhere, the method indicated by Dr. Pacaud is obviously a very practical one. For our own part, we are inclined to think that the application of vinegar would be just as efficacious; and we may point out that the soothing effect of acid substances in general (plain or aromatic acetic, dilute hydrochloric acid, etc.,) on pruritus, from whatever cause, has long been recognized.—*North American Practitioner.*

### Sanborn (G. H.) on Adpendicitis.

Conclusions are:

1. That in all cases the physician is concerned only in the early recognition of the disease, the subsequent treatment to be left to the surgeon.
2. That the catarrhal or mild form of appendicitis may be considered the only medical form of the disease; and delay in operating may be encouraged to a reasonable extent.
3. All cases of appendicits which, at the end of thirty-six hours from the beginning of the attack, show signs of increasing disease, should be operated on.
4. That the majority of so-called recoveries, treated medically, are not recoveries in the full sense of the word, but simply a respite which enables one to settle worldly affairs, and take out a life-insurance policy, in anticipation of a fatal termination.
5. The early surgical treatment of appendicitis enable us to avoid in every case uncertain results of a spontaneous cure, the d anger of recurrent attacks, and the often fatal general peritonitis in apparently mild cases.—*Brit. Med. and Surg.*

### Catarrhal Otitis.

Dr. H. N. Spencer, of St. Louis, in the *International Medical Magazine*, says: "In children, where we may not be able to use the post-nasal spray, the head should be held well back and an injection of the fluid through the nostrils should be made by means of a dropper or an opened-mouth syringe. Such a solution as the following might be employed:—

℞ Sodii biborat.....gr. v
Tinct. benzoin. co.....mx
Glycerin.....mxx
Aquæ.....q. s., ad. ʒj.—
M.

"Two or three drops of pure olive oil may be applied after this, or an oleaginous solution composed as follows:—

℞ Menthol.....gr. iij
Camphor.....gr. v
Benzoinol.....ʒj.—
M."

## ARMY AND NAVY.

U. S. ARMY FROM MARCH 4, 1894, TO MARCH 10, 1894.

Leave of absence for one month is hereby granted Captain R. B. Ball, assistant surgeon, U. S. Army, Fort Monroe, Va.

Captain R. W. Johnson, assistant surgeon, U. S. Army, will proceed to Fort Monroe, Va., for temporary duty, during the absence, on leave, of Captain R. B. Ball, assistant surgeon. Upon the return of the latter from leave, Captain Johnson will return to his station, Washington Barracks, S. C.

First-Lieut. Charles Wilcox, assistant-surgeon, U. S. Army, is relieved from temporary duty at Boise Barracks, Idaho, and ordered to return to his proper station, Pnesido, of San Francisco, California.

Leave of absence of one month is granted Major Timothy E. Wilcox, Surgeon, U. S. Army.

The leave of absence granted Major John D. Hall, Surgeon, U. S. Army is extended one month.

Leave of absence for four months to take effect on or about August 10, 1894, is granted Captain Henry I Raymond, Assisstant Surgeon.

Major John Van. R. Hoff, Surgeon, U. S. Army, is hereby assigned to the charge of the office and duties of the Medical Director. Headquarters Department of the East, during the temporary absence of Colonel Joseph R. Smith, Assistant-Surgeon General Medical Director of the Department.

## NEWS AND MISCELLANY.

Dr. Thompson S. Westcott has been elected Attending Physician to the Methodist Episcopal Hospital in Philadelphia, vice Dr. F A. Packard, resigned.

### The Association of Military Surgeons of the United States.

The fourth annual meeting of "The Association of Military Surgeons of the United States," will be held in Washington, D. C., May 1st, 2nd and third, 1894.

This National Organization is composed of Medical officers of the U. S. Army, U. S. Navy, National Guard of the United States, and the Hospital Marine Service—in whose service are many of the most celebrated and distinguished surgeons of our country. A brilliant and able literary programme will be presented. The afternoon of one day will be set apart for an object lesson from the "Manual of Drill," by the Hospital Corps. The evenings will be given up to social entertainments. There will be about five hundred delegates in attendence.

GEORGE HENDERSON,
*Chairman Committee of Arrangements.*

### American Medical Association, San Francisco, Cal.

The committee of arrangements has secured Odd Fellow's Hall Building Corner Market and Seventh streets, for the meeting June 5th, 1894.

Assembly Hall, for the general meeting, has a capacity of 1,500; the twelve smaller halls for section work, range in capacity from 500 downward, with committee rooms adjacent.

The engagement carries three of these rooms on Monday for accommodation of associate organizations, as that of the editors, colleges, etc.

The banquet room on the ground floor, 65x95 feet, will be devoted to exhibition purposes, for which it is admirably adapted, and has been secured for the entire week that exhibitors may have Monday in which to place their goods, and Saturday in which to remove them. Nearly half of the space is already taken, and others who desire to make a display of their goods under the most auspicious circumstances ever presented on the Pacific coast, should lose no time in applying to chairman for space.

Headquarters for the Association have been located at the Palace Hotel cor. Market and Montgomery streets, only four blocks from the place of meeting. Here we have "Marble Hall," 30x40 feet, as a registration room where work will begin on Monday, and parlor A for committee work.

The following hotels, centrally situated and convenient to the place of meeting, have quoted special rates for members and their families, which will apply during the entire stay of the guests, who should upon registering, signify that they are in attendance upon the meeting of the Association.

The rates quoted are for single persons, the variation depending upon the size, situation and appurtenances of the rooms, as single, en suite, with private bath, etc. Special arrangement will be made for families or parties on timely notice.

Some of the hotels entertain upon the American plan only; some upon the European plan only, and some upon either plan to suit guests.

Palace Hotel (headquarters) American plan (rooms and board) $3.50 to $5.50 per day; European plan (rooms only) $1.50 to $3.50 per day. Baldwin Hotel, American plan, $3.50 to $5 per day; European plan, $1 to $3 per day. California Hotel, American plan, $3.50 and up per day; European plan, $1.50 and up per day. Lick House, American plan, $250 and up per day; European plan, $1.00 and up per day. Occidental Hotel, American plan (only) $2.50 and up per day. Hotel Pleasanton, American plan (only) $2.50 to $5.00 per day. Russ House, American plan, $2.00 to $3.50 per day; European plan, $0.50 to $2.00 per day. Grand Hotel, connected with the Palace by a glass-enclosed bridge across New Montgomery street, European plan only, $1 to $2 per day.

In addition there are many other hotels, boarding houses and restaurants contiguous to the place of meeting, where one can be made happy and comfortable at less cost.

Post office, Section R., is located in the Palace hotel on the office floor adjacent to the Registration room, where members can receive all mail matters by having it so addressed.

More anon,
R. W. PLUMMER, *Chairman.*

RED GLASS is to be tried in one of the small pox pavilions at North Brother Island, New York, in order to test the value of the experiments made by Drs. Lindholm and Vinsen of Bergen, Norway, who claim that the pitting of small pox patients is due to the sensitiveness of the skin to violet rays of light.

AT A SALE of unredeemed pledges at a London pawnbroker's, there was purchased the casket in which the freedom of the city of London was presented to Jenner on the 11th of August, 1803, for "his skill and perseverence in the discovery of, and bringing into general use, the vaccine inoculation."

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### TREATMENT OF ERYSIPELAS WITH HYPODERMATIC INJECTIONS OF CARBOLIC ACID.

J. McFADDEN GASTON, M. D., Atlanta, Ga.

Having noted in the discussion of a case of erysipelas, before the Louisville Clinical Society, that Drs. A. M. Vance and J. M. Krim lay great stress upon the local application of carbolic acid, I feel prompted to give my experience confirmatory of its efficacy when used hypodermatically in this disease.

About twenty years ago my attention was directed to this remedy by a report of successful results in an English medical journal, and, finding that it fufilled all that was claimed for it, I have employed it frequently in all the various forms of erysipelas which have come under my care. It has been attended with invariable good effects in promptly arresting the progress of this disease. In some cases no other treatment has been employed, so as to test its virtues without resorting to constitutional measures, and the effect has been entirely satisfactory.

I recall only a single case during all this period, which did not yield to this treatment and that was in a patient, to whom I was called in consultation, at an advanced stage of erysipelas, involving the entire scalp, accompanied with coma. As an offset to this, I have frequently employed the carbolic acid hypodermatically when the scalp was partially involved in erysipelas, with complete relief.

I am reminded by the allusion of Dr. W. H. Wathen, during the same discussion, to complications of delivery at term with erysipelas, of a case in which there was a face presentation, requiring prodalic version and followed by erysipelas of the genitalia and the hypogastric region. The injections, hypodermatically of carbolic acid in various portions of the area affected was crowned with complete success.

The formula employed by the original reporter, when name is not remembered, was a solution of carbolic acid in dilute alcohol. But this was modified by me afterwards, and I have used during the past ten years the following:

℞ Carbolic Acid..... ʒ i
Glycerine..... ʒ iii
Distilled water..... ʒ iv

Mix and inject hypodermatically one syringeful in each portion of the size of a hand, daily.

It will be observed that this is a 12½ per cent. solution, and only in a few cases has any local irritation resulted from the injection.

When the thickened and hardened condition of the skin has rendered it difficult to introduce the needle, I have selected points on the border of the dermatitis to make the injection, so as to reach the areolar tissue beneath the skin. There is little pain connected with it. I am convinced that many cases of erysipelas will yield to this treatment; but it does not preclude the resort to any internal means which may be indicated, and when the extent of surface involved is large or the febrile condition is great I have used internal remedies.

The best effects have been secured by giving at the outset calomel, followed by Epsom salts in senna tea, to procure free

evacuations from the bowels. After purgation I have given 25 drops of the muriated tincture of iron every three hours until an ounce is taken. In some cases chlorate of potash in 10 grain doses has been combined with the iron, especially when there is a tendency to the phlegmonous form of erysipelas.

But when I am called early to the case and find the erysipelas circumscribed, I rely upon the hypodermatic use of the formula given above and rarely have any occasion to employ other means of cure.

An instructive case was presented a few years after commencing the use of this remedy. Having treated an acute case of erysipelas in the family of a man, he informed me that he was subject to a periodic recurrence of this disease in his feet and legs, every Spring. I had an understanding with him to give me notice of the next appearance, with a view to test the remedy in this chronic state. In the course of time I was called, and found a well developed case of erysipelas on both legs, extending up to the knees. The carbolic acid was used hypodermatically in two places on each leg, and repeated on two successive days, without any other treatment. All traces of the disease disappeared, and during five years subsequently there was no return of the disease, nor did there seem to be any threatening of future trouble.

In this instance the elimination of disease was complete and indicates a specific action of carbolic acid in the cure of erysipelas.

The influence upon the system of such an injection is general and not confined to the immediate location of the puncture, so that it may be considered as a constitutional impression of the remedy. Some caution is requisite against an undue quantity of this solution of carbolic acid being used on one occasion, but a toxic influence is manifested. But I have repeatedly introduced a syringe-full of the solution in four different places, without producing any untoward effect, and hence it may be allowed that this quantity, distributed over an area of four hands' breadth, is entirely safe. It is also found proper to repeat the injections daily for three days, but I have never had any occasion in which it was requisite to continue the treatment for a longer time. My patients have generally been so far relieved within three days or less time, as to dispense with further injections.

## LAVAGE IN THE TREATMENT OF DISEASES OF THE STOMACH.

PHILIP HURT STRAUSZ, M. D., Toledo, Ohio.

I have noticed, from time to time, articles in our medical journals on the treatment of dyspepsia, and have been surprised at the want of mention of one of the most important adjuncts to the treatment of almost all forms of stomach difficulty, viz., Lavage, as practiced by Dr. Dujardin-Beaumetz, of Paris, France.

I have for several years paid special attention to diseases of the alimentary canal and have given much thought to washing the stomach, having in the last five years washed every case of chronic stomach trouble that has presented itself to me for treatment. In the first place it seems to be the only rational means we have for a certain diagnosis of the character of disease the patient may have, for as all know the term dyspepsia conveys little if any meaning, being only a symptom of an organic disease.

I would like to give some of my experience with the straight tube. I always have my patient present him- or herself, from four to six hours after having eaten, when I usually find the stomach free of all food. If, after trying to introduce my tube there be much reflex irritation, I at once introduce about one ounce of a saturated solution of Calcium sulphide to reduce this state, which it does. After having filled the stomach about one-third full of plain water, at a temperature of about 112° F., I syphon this first water off into a clean vessel, saving this result for diagnostic purposes. I continue to use plain water during the first sitting 'til the water returns through the syphon as clear as when introduced into the stomach. I then make my examination of the first liquid and usually diagnose my case from that.

I have treated many cases of ulceration of the stomach, with the most gratifying results, both to the patient and myself, by using in these cases first a solution of resorcin, washing thoroughly with this aseptic water, after which I use about ʒi of Bismuth subnitrate to a pint of water, letting this water remain in the stomach about two minutes and then syphoning it off, thereby coating an aseptic sore with the Bismuth.

In atonic dyspepsia, when the muscular walls are so much relaxed as to hardly perform any function, the continued ingestion of hot water seems to impart to them a stimulation and, with the addition of large doses of Strychnia sul., will regenerate an almost worn out stomach.

I have had case after case of catarrh of the stomach, where the mucous glands have been stimulated to such an extent that their secretion overrides all others, and where I have been able to syphon at my first washing not less than one pint of a thick, vicid mucous, so heavy that it sinks to the bottom of the receptacle like lead. Almost complete relief is given in these cases by the employment of an antiseptic wash, followed by the use of arsenate of Copper in $\frac{1}{100}$ grain doses each morning, taken in a glass of hot water. This form of dyspepsia is the most common and persistent that will come to the physician, and requires great patience on the part of both physician and patient.

Another very prevalent form of dyspepsia is what is known as putrid indigestion, where the patient's stomach fills with the accumulating gasses of putrefaction and causes not only pain to himself, but disgust to his friends who are unfortunate enough to be associated with him. In this form it has been my custom to use a solution of permanganate of potash until the reflex shows the entire absence of organic matter in the stomach which will occur after the injection of about one gallon of water.

I could go on and mention the different forms of disease of this most important organ treated by lavage with proper medication, but hardly think it worth while, as I leave it to the physician to use his own judgement as to what is required in each form. What I wish to impress is that the unpopularity of this method of treatment of disease of the stomach is due to the fact that almost all practitioners use the same solution in every case that presents itself, whereas each form of dyspepsia requires a separate and distinct form of medication as does any other disease. If the physician will first of all diagnose his case, his own knowledge of medicine will indicate the treatment required, and I can assure him, after an experience of many years, that the results will prove satisfactory.

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**Special Exercise to Correct and Prevent Constipation.**

Friction, rubbing, or massage over all parts of the abdomen two or three times per day by the patient himself, or less frequently by a good magnetic operator will help promote vital action of the bowels. If not convenient for the patient to walk or ride for exercise, he can secure the advantage of both in large degree by the following exercise taken in his room:

Standing with the feet well apart to broaden your base, bend or flex the lower limbs at the knees and extend the same about twice a second, or one hundred times a minute, for several minutes at a time, three or four times a day, and at the same time twist or turn the body above the hips first to the right and then to the left as far as you well can, resting the hands upon the hips or allowing them to hang by your side. At each turn of the body toward the right or left you will bend the knees about three or four times. You thus use chiefly the flexors and extensors of the thighs, and the rotating muscles of the trunk. The motion of the body is meanwhile up and down, and the motion of the chest and head is alternately to the right and left. To facilitate the turning of the body, the heel of the limb opposite the one on which you rest, as the body sways from side to side, may be raised so as to allow the limb to turn upon the ball or toe of the foot. To get the best effect of this exercise the head must be kept well up, the shoulders back and the spine erect during exercise. The bowels may generally be allowed to rise and fall with the body, but at times it is well to exercise the diaphragm by endeavoring to draw up beneath it the liver and viscera of the abdomen.—Dr. Dutton, in *Jour. Amer. Health Society.*

# COMMUNICATIONS.

## REMOVAL OF THE GASSERIAN GANGLION AS THE LAST OF FOURTEEN OPERATIONS IN THIRTEEN YEARS FOR TIC DOULOUREUX.*

W. W. KEEN, M. D.,† AND JOHN K. MITCHELL, M. D.,‡

MEDICAL HISTORY BY DR. MITCHELL.

J. T. K., aged forty-one years; married; dental surgeon. Until his thirtieth year he was in excellent health, and had no indications of any tendency to neuralgic disease. The history was in every way a good one up to the beginning of the present trouble, with the exception that he was born after a labor prolonged for four days.

The patient was small but strongly built, though when first seen in a much reduced state physically, and in a condition of severe nervous and moral prostration. There is a marked difference in the color of the two eyes, the right one being brown and the left blue.

In 1880, without any previous warning, he had a sudden attack of violent pain in the right upper jaw, nearly limited to one tooth. This came on during a meal. The tooth was extracted, but the pain continued in the socket from which the tooth was withdrawn until this healed, when the pain began in another tooth, and the process was repeated until three were drawn. Only one of these, the twelve-year-old molar, which had been filled some years before with tin and amalgam, was found in an unhealthy condition. The roots were perfectly dry and the foramen very much enlarged. Some portions of the alveolar process, it is said, came away with the extraction of this tooth, and this was also dry and unhealthy-looking. The following summer a portion of bone of that alveolar margin was removed for necrosis. After the parts were healed the pain ceased, with the exception that occasionally at the side of the molar tooth a sharp pain, like that of an exposed nerve, was felt if the part were touched. This also disappeared during the following few months.

In February, 1881, while washing his face, the patient felt a pain shoot through the infra-orbital region, which increased in severity from day to day until he had to stop work on account of it. After a deal of suffering, his physician, Dr. Kirk, of Fox Chase, brought him to Dr. R. J. Levis, who after examination thought that the pain was caused by the gums contracting so as to press tightly upon the nerve radicles. This he attempted to remedy by cutting loose the gum from the bone for the whole depth of the process, both on the palatal and buccal sides; but no benefit was felt from the operation, and later Dr. Levis cut down upon the infra-orbital nerve at the foramen and removed a small portion of the nerve, again without succeeding in relieving the pain.

After suffering great agony for some weeks, Mr. K. was advised to have his upper teeth extracted. In the attempt to do this the eye-tooth was broken in the gum, and the root could not be removed until Dr. Garretson extracted it some time afterward, and in examining the mouth found a necrosis of a portion of the upper jaw, which he removed.

For a short time the pain in the face was much better, but became finally so very severe in the region of the infra-orbital again, that Dr. Garretson cut down upon the infra-orbital nerve and removed all the portion interior to the foramen, finding the nerve intact. This was in September, 1881.

No further operation was done until February, 1883. Mr. K. matriculated in the Philadelphia Dental College in 1881, but on account of his sufferings was obliged to desist from work. In the spring of 1883, pain returned in a small area in the side of the upper jaw, and the sixth operation, undertaken by Dr. Garretson, re-

* Read before Philadelphia. Co. Med. Soc. February 14, 1894.

†Professor of the Principles of Surgery and of Clinical Surgery in Jefferson Medical College; Surgeon to the Orthopædic Hospital and Infirmary for Nervous disease, etc.,

‡Physician to St. Agnes' Hospital; Assistant Physician to the Orthopædic Hospital and Infirmary for Nervous Diseases.

moved a portion of the upper jaw, exposing the antrum. The patient had comparative ease until the fall of 1883, when the pain began again, and he was variously treated during the succeeding four or five years without much relief.

In the winter of 1887-88 he suffered dreadfully, and in March Dr. Garretson made a resection of the second division of the fifth nerve on the affected side, this being the seventh operation, but how much of the nerve was removed is not stated.

In March, 1889, the third division of the fifth nerve, back to the foramen ovale, was resected by the same surgeon, with much relief; but the pain soon returned, and the ninth operation was the ligation of the facial artery in 1890. In September of the same year, the tenth operation took place—an excision of the whole upper jaw. In September, 1891, Dr. Garretson did the eleventh operation, by opening, at the patient's request, the inferior dental canal and removing the nerve as far forward as the foramen.

From each of this frightful series of operations the patient experienced some temporary relief, with the exception of the one or two otherwise noted. On admission to the Orthopædic Hospital and Infirmary for Nervous Diseases, in May, 1893, he was suffering from three or four paroxysms of severe pain a day, for the relief of which he was taking half a grain of morphine twice a day, and more if the attack was too painful to bear. The right face was sunken, wasted, and seamed with the scars of the several operations; and, in spite of the removal or cutting of the various branches of the fifth nerve, the upper part of the face was still very sensitive, so that to twitch the eyelid, or scratch the right eye, would cause a violent outburst of pain in the *lower jaw*, running forward to the corner of the mouth.

An area of diminished sensation was found upon the outside of the cheek extending from the lobe of the right ear throughout the distribution of the fifth nerve, under the right eye to the median line of the nose and to the median line of the lips. Sensation was not lost in this area, but much diminished, and heat and cold were perfectly distinguished throughout the region.

A few days after his admission a small corneal ulcer was observed upon the outer side of the right eye, midway between the pupillary margin of the iris and the periphery.

The first week in June, Dr. Weir Mitchell and Dr. Keen had a consultation and decided to examine the condition of the inferior dental nerve, in view of the possibility of its having regenerated as to cause the pain which centred in the lower jaw. The severity and frequency of the paroxysms by this time had somewhat diminished from those which occurred on his admission to the hospital, but the smallest movement of the tongue against the cheek or lips would cause paroxysms; to open the mouth at all widely, to put a finger against the cheek, would all bring on furious pain. A small portion of the right cheek immediately below the eye was totally anæsthetic to touch, extending from near the middle line on the right of the nose down to and including the ala of the nose and out upon the cheek about one and one-half inches. The right angle of the mouth was capable of very little movement, and the lower eyelid was almost completely paralyzed.

The site of most severe suffering was not at this time at the mental foramen, but about an inch posterior to it. From this point the pain spread throughout the inferior dental distribution.

Removal of the Gasserian ganglion was proposed by Dr. Keen at this time, but as the patient preferred that a new attempt upon the inferior dental nerve should be tried first, Dr. Keen consented to this, and on June 10, 1893, operated.

SURGICAL HISTORY BY DR. KEEN.

An incision was made in the line of one of the old scars near the lower border of the lower jaw. The soft parts being lifted at the site of the mental foramen, a very minute opening was perceived to which the soft parts were adherent by a little thread which may have been a nerve but which tore with slight traction. About an inch and a quarter back of this supposed mental foramen was another quite large foramen corresponding to the focus of pain, from which came out what appeared to be a nerve, which spread out fan-like in the soft parts. This was excised and placed in Müller's fluid. Between the two foramina a button of bone

was removed, but no canal and no nerve could be discovered. I then chiselled away the bone back to and under the large abnormal foramen just mentioned, and found the inferior dental nerve as a thick cord, and followed it backward to the inferior dental foramen. When I seized the nerve to extract it from its bed, although the patient was profoundly anæsthetized he struggled considerably. An inch and a quarter of the nerve was resected from the abnormal opening backward, the nerve being drawn down as far as possible. The upper opening was then closed by a sheet of sterilized gold-foil and the lower portion of the bone, where it had been trephined half through its substance and chiselled backward, was filled with dental cement made of oxide of zinc powder and glacial phosphoric acid. The operation was characterized throughout by exceedingly troublesome hemorrhage, which Dr. K. tells me was characteristic of the former operations also. A dozen strands of silkworm-gut were laid in the wound for drainage, and the wound closed and dressed as usual. He made a prompt recovery. Neither the gold-foil nor the cement has given the slightest trouble.

On the 24th of August he was re-admitted, having suffered much pain again for a month. He describes the pain as being in the right cheek, coming on in paroxysms, induced by eating, talking or any movement of the lips, teeth or cheek. The slightest stroking of the cheek will bring it on. He has no pain if the parts can be kept absolutely immovable. The areas of paræsthesia on the right side of the nose and cheek seemed to be somewhat more sensitive, and this time the pain complained of is all above the level of the inferior maxillary. In the absence of Dr. Keen, Dr. Wm. J. Taylor operated again on the 28th of August, removing the tissues about the infra orbital foramen, with only temporary relief. Early in September the pain had returned as violently as ever, and even large and frequent doses of morphine failed to relieve him. Accordingly he re-entered the infirmary in October, with the intention of undergoing the removal of the Gasserian ganglion.

*Operation,* October 18, 1893, by Dr. Keen. One-thirtieth of a grain of strychnine and a quarter of a grain of morphine were given him just before beginning the etherization. An omega-shaped incision was made, the length of which, vertically, was three inches. One leg terminated immediately in front of the tragus, the other just in front of the junction of the anterior and middle thirds of distance between the external auditory meatus and the external angular process. The temporal artery was cut and this and a few other vessels required ligation. Dr. M. H. Cryer, with the new surgical engine of S. S. White & Co., and a circular saw one and a half inches with a guard, then rapidly and very successfully divided the external table, excepting the two extremities. Here, fearing perforation before the inner table and the rest of the flap were divided, I determined to chisel through. I first chiselled the superior four-fifths of the flap, passing through the inner table with ease, and then chiselled the extremities. At the posterior terminus when I was only giving an ordinary light blow with the mallet, the chisel suddenly penetrated the skull to a depth of perhaps half an inch, and immediately a considerable hemorrhage showed me that the posterior branch of the middle meningeal had undoubtedly been cut. I then chiselled quickly through the anterior extremity, broke the bone and reflected the flap. Here again was an additional trouble, for the anterior branch went through a distinct canal at the anterior inferior angle of the parietal bone, and of course was torn and bled freely as I turned down the flap of bone and scalp. A finger over each artery, however, almost controlled the hemorrhage, and in a very few moments I was able to place a pair of hæmostatic forceps on each. A cut was seen in the dura corresponding in length to the width of my chisel. A small curved Hagedorn needle was then passed first around the anterior branch in the dura, then the posterior branch was caught. The opening in the dura was sutured by catgut. The middle lobe of the brain was then lifted with care and great gentleness from the bone, but this was followed by hemorrhage which might well be called alarming. Lifting up the middle lobe with a spatula, I discovered that it was not, as I had feared, from the middle meningeal ruptured at the foramen spinosum, but that the blood came from the neighborhood of the ganglion. I could not think, with the gentleness I had used, that the cavernous sinus had been ruptured, but

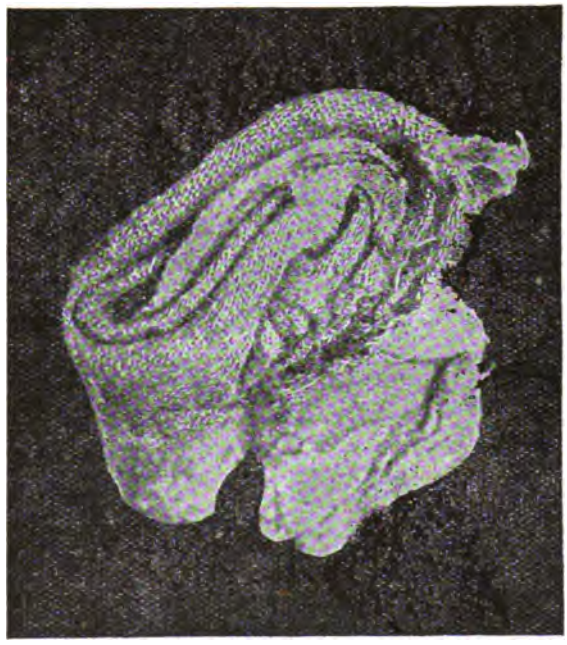
at all events it was too free, not only to allow of removal of the ganglion, but for the integrity of the man's life if it continued. The hemorrhage did not yield to hot water. I packed it twice with gauze which arrested it temporarily, but on removing the gauze it bleed as freely as ever. Accordingly I packed in a considerable piece of iodoform gauze and closed the flap by six retention stitches, with the intention of removing the packing in two or three days and then removing the gang lion. Before packing, the dural wound was closed by a stitch of catgut.

no spots in the eye ground. A field roughly taken shows no limitations.

21st. (Third day.) Since the operation the patient has done well, excepting that he has had, of course, a number of paroxysms of pain. The only evidence of increased intra-cranial pressure due to the gauze, has been a slowing of the respiration down to from six to ten, and a slight aphasic condition. The gauze was introduced on the right side of the head and he is a right-handed man. The highest temperature was 100.8° F.

To-day I opened the wound, which was

FIG. 1



Shows the natural size of the piece of iodoform gauze (37 x 6 inches) packed in the cavity of the skin for three days without harm; seen edgewise.

During the operation he had received in all one-eighth of a grain of strychnine, and an hour after the operation was completed was in bed with warm extremities, a pulse of 80, temperature of 98°, but a respiration of only 8 in the minute but very deep. His color was very fair.

October 20th. His eyes were examined by Dr. G. E. de Schweinitz, who reported as follows: "Irides unlike in color: right brown and left blue. Pupils very small, right smaller; reaction normal. Scar in right cornea. Oval optic disk, paler than normal; veins full and larger than usual; arteries normal. No swelling of disk and

partly united. The small cut in the dura, made by my chisel three days before, was entirely closed, and there was not the slightest evidence of any harm from it. I drew out the gauze very carefully, keeping a stream of hot water playing on it all the time so as to loosen it very thoroughly. I found on measurement that the piece was 37 by 6 inches. (Fig. 1.) It weighed 2½ ounces, and a similar piece, dry, weighed 2½ drachms, showing that it had absorbed 17½ drachms of blood. (Fig. 2.) On withdrawing it I was very fearful at first that the hemorrhage, which was moderately profuse, would again prevent my

doing anything to the ganglion, but on introducing some small hot sponges I was able to overcome the bleeding in the course of a little while by the heat and pressure. Evidently the hemorrhage did not come from the cavernous sinus, nor from the middle meningeal, both of which I found to be intact.

In a few moments I was able to expose the middle meningeal artery and the second and third divisions of the fifth nerve, and see also the little flap of dura which covered the ganglion. I had great trouble in separating the third division from the middle meningeal, as they ran very close together. Moreover, both at the second and third divisions, the slightest touch of the blunt hook, Allis's dissector, scissors, knife, anything, produced the sudden escape of at least a drachm of blood, which obscured the field of operation. Pressure by a small gauze sponge for a very few moments would cause the bleeding to cease, but the slightest manipulation produced its recurrence again. However, after cutting both of these nerves and tracing them back to the ganglion, I tore the little extra-dural sac open, and with the Allis dissector and a small sharp spoon I thoroughly destroyed the ganglion.

The wound was then closed and the usual dressings applied. The patient's condition both throughout the operation and at its end was decidedly better than at the operation on the 18th.

He made a complete and rapid operative recovery and was out of bed on the fourth day, the entire wound being healed. The highest temperature was 101.2.° The aphasia gradually bettered and finally disappeared. He complained bitterly of pain in the head at first, but this soon diminished, especially after the roots of two teeth were kindly removed by Dr. Cryer. Soon after the operation, the morphine being stopped after the first five days, he had the most intense mental depression. In fact, this went to such a degree and assumed such delusional forms that I was doubtful whether it was due to possible cerebral changes from the three days' pressure of the gauze, or to the withdrawal of the morphine alone, and I seriously feared a permanent insanity. Bromides, strychnine, and sulphonal were all used in turn and in full doses, but none of them did him any good. Finally, codeine in ¾-grain doses in the twenty-four hours gave him relief in sleep and checked his delusions, so that in a few days he was quite recov-

FIG. 2.

The same piece of gauze; seen sidewise.

ered, and since then until the present date, February 14, 1894, has been absolutely rational, free from delusions and pain, and without any desire for his morphine, which on the contrary he loathes after thirteen years of slavery to its use. His eyes were examined by Dr. de Schweinitz, and found to be in the same condition as on October 20th. Glasses were fitted which gave him excellent vision.
(Fig. 3.)

His condition, from a neurological standpoint, will be stated by Dr. J. K. Mitchell.

REMARKS BY DR. KEEN.

First, as to the method of operating. Horsley's operation by a temporal flap, opening the dura and tearing the roots of the fifth nerve behind the ganglion from the pons, seems to be needlessly severe. As between the Hartley-Krause operation, which I adopted, and that of Mr. Rose,* through the base of the skull, I think there is no question that the easier operation is that devised by Dr. Hartley,† and soon afterward and independently by Krause.‡ The table (*vide infer*) shows that thus far they are equally safe. There is much more room for the manipulations by this method than by Rose's, in which one to a great extent works in the dark, through a very small opening. Moreover, Tiffany§ has made the important observation that a deliberate opening of the dura, by allowing the escape of considerable cerebro-spinal fluid, gives much additional room for the intra-cranial manipulations. It will be noticed that the two ends of my incision were placed the one directly in front of the tragus and the other in front of the junction of the anterior and middle thirds of the distance between the external auditory meatus and the external angular process. By examining the skull I have found that this marks, as nearly as may be, the anterior limit of the middle fossa of the skull, and gives, therefore, the widest opening possible for access to the interior. It has the disadvantage that it impinges upon the canal, if there be one, for the anterior meningeal; but anyone accustomed to controlling hemorrhage in the skull should certainly be able to cope with this difficulty, and if the artery,

FIG. 3.

The patient after recovery, showing scars of various operations.

*British Med. Journ.*, 1892, i. 53.
†Annals of Surgery, May, 1893, p. 571.
‡Arch. f. klin. Chir., xliv. p. 821.
§Annals of Surgery, February, 1894.

as is usual, does not run in the canal, no trouble will occur. The advantage of making the flap of scalp and bone, as was done by the osteoplastic resection of Wagner-Wolff, instead of trephining, is, I think, very great, the larger opening being an advantage of the first moment. Moreover, the two ends of the incision should be carried well down, almost to the level of the zygoma, so that the middle fossa will be opened almost completely down to its floor, otherwise the manipulations are much more difficult. The division of the skull by Dr. Cryer with the surgical engine was only moderately satisfactory as to speed. Since then I have had made, at the instance of Dr. E. T. Darby, a drill with two spiral threads which answers the purpose very much better on acconnt of the rapidity with which it divides the bone. Dr. Cryer has figured another drill for the engine, which he says will work more rapidly, but with which I have had no experience. The diagram seems to me to point toward a successful instrument.† In dividing the posterior portion of the bone, it will be noticed that my chisel, by a blow which was not deemed to be too severe, penetrated the cavity of the brain to some extent, but also, what might have been a serious complication and was for a time an embarrassing one, divided the posterior branch of the middle meningeal. This accident has cautioned me as to the use of the chisel. Instead, I should have used Hartley's or some similar osteotome, which, being conical throughout instead of with parallel sides as the chisel had beyond the bevelled edge, would have prevented this accident.

Unfortunately, also, I had to deal with a "bleeder" as was proved by the prior operations, and I presume this was the reason why the hemorrhage was so profuse on the gentle lifting of the temporosphenoidal lobe in the middle fossa. No one with ordinary prudence would attempt to remove the Gasserian ganglion while the field was filled with blood, as fatal injury might be done to the carotid or to the cavernous sinus which lie in such immediate proximity to the ganglion. I think the introduction of the gauze, following the suggestion and practice of Krause in his first operations of this sort, was the wisest step I could have taken. The hemorrhage three days later, when I removed the gauze, was comparatively profuse, but the operation was successfully completed. I was very much surprised, however, when I withdrew the gauze to find that I had packed in so large a piece. It covered 222 square inches, and formed a large wad, which, as it will be observed, had absorbed two ounces and a drachm and a half of blood. It has puzzled me a good deal to account for the absence of symptoms other than the slowing of the respiration and the slight aphasia, as a result of such a large foreign body within the cranium. Possibly a little might be accounted for by the slight yielding of the flap; possibly more by the slight escape of cerebro-spinal fluid by my puncture of the dura; but allowing for all this, the foreign body was a very large one, which must have produced a great deal of pressure. I certainly never introduced so large a piece before, and the fact that four days after it was removed the patient was out of bed with the wound practically healed, showed how rapid was the recovery. That gauze can be left for a long time within the cavity is well known, and has recently been excellently illustrated in a case reported by Dr. Chalmers Da Costa, in which a piece of gauze 8 by 1 inches was retained for thirteen days within the cavity of the skull.

Second, the results of removing the ganglion are, of course, not yet absolutely determined. The first case was operated on by Mr. Rose in 1891.* Since then I have been able to collect 40 cases operated on by the two methods, and the result thus far is as follows: Of the 40 cases, 6 have died and 34 recovered. In none of them has there been any return thus far reported, excepting a partial return in one of the earlier cases of Mr. Rose. In no other case than his first one has there been the loss of an eye, and neither Dr. Tiffany in the 4 cases he has reported, nor I, took the least precaution for the protection of the eye, by preliminary temporary suturing of the lids. The results thus far seem to encourage us very much. If the removal of the ganglion should in time prove to be a final cure in cases of tic douloureux, my own opinion would be that it should be the *first* operation recommended for severe cases, provided that time and experience enable us to diminish the present relatively large mortality. If,

†In a later case at the Jefferson Hospital, Dr. Cryer kindly used this drill for me, and with great advantage.

* British Medical Journal, 1892, i. 261.

however, the pain should return in any considerable proportion of the cases, then, as this is the final and terminal operation, I would certainly advise my patients hereafter to have repeated peripheral operations done, gradually approaching the centre; and the removal of the ganglion, should the pain return again and again, should be the *last* operation. In other words, if the operation of removal of the ganglion proves to be an unqualified success and its dangers are lessened, we should begin with that and not waste time with peripheral operations. If it is only, like the peripheral operations, a temporary relief, then we should begin at the periphery and work toward the ganglion by as slow steps as it is possible to take.

with the condition previous to the operation. He had no spontaneous pain in any part after the operation, and at the time of his discharge the aphasia had entirely disappeared as well as the mental depression.

In the regions supplied by the supra-orbital nerve, sensibility to touch was diminished as far as the vertex upward and forward to the median line of the face from the lobe of the ear and the lower border of the inferior maxilla. The mucous membrane of the lips and cheek on the right side, and the right side of the tongue were also partially anæsthetic. On the right side the sense of taste was entirely lost. The ocular and palpebral conjunctivæ were insensible to touch, but

TABLE OF OPERATIONS FOR REMOVAL OF GASSERIAN GANGLION.

| Author | Reference | Recovered | Died | Total |
|---|---|---|---|---|
| Rose* | British Medical Journal, 1892, i, 261 | 5 | .. | 5 |
| Rose* | Lancet, 1892, ii, 953 | 1 | 1 | 2 |
| D'Antona* | British Medical Journal, 1893, i, 81 | 1 | .. | 1 |
| Park* | Trans. Amer. Surg. Assoc., 1893, vol xi. 238 | 2 | .. | 2 |
| Andrews* | Journ. Amer. Med. Assoc., Feb. 18, 1893, 180 | 3 | 1 | 4 |
| Krause† | Annals of Surgery, Sept 1893, 362 | 5 | .. | 5 |
| Roberts† | Proc. Philadelphia Co. Med. Soc., 1892, 490 | 1 | .. | 1 |
| Lanphear* | Pacific Medical Journal, 1892, xxxv, 647 | 1 | .. | 1 |
| Hartley† | Annals of Surgery, May, 1893, 511 | 1 | .. | 1 |
| Doyen* | Rev. de Chir., 1893, 391 | 1 | .. | 1 |
| Horsley‡ | British Medical Journal, 1891, ii, 1191 | .. | 1 | 1 |
| McBurney† | Annals of Surgery, 1893, i. 516, 519 | 2 | .. | 2 |
| Parkhill* | Medical News, Sept. 16, 1893, 319 | 1 | .. | 1 |
| Edw. Kerr* | Jour. Amer. Med Assoc. Feb. 18, 1893, 181 | 1 | .. | 1 |
| Fernandez§ | Siglio Med. Madrid, 1892, 804, 819; 1893, 4, 18, 36 | .. | 1 | 1 |
| Fowler† | Personal communication | 1 | 1 | 2 |
| Tiffany† | Annals of Surgery, Jan., 1894, 47 | 4 | .. | 4 |
| Finney† | Johns Hopkins Bulletin, Oct., 1893 | 2 | 1 | 3 |
| Novaro* | Jour. de Med., Chir. et Pharm., Bruxelles, Sept. 20, 1891 | 1 | .. | 1 |
| Keen and Mitchell† | The present case | 1 | .. | 1 |
| | | 34 | 6 | 40 |

| | Cases | Recovered | Died | Mortality per cent |
|---|---|---|---|---|
| * Rose's method | 19 | 17 | 2 | 10.5 |
| † Hartley's method | 19 | 17 | 2 | 10.5 |
| ‡ Horsley's method | 1 | 0 | 1 | 100.0 |

§ Method unknown. Reference furnished me by Dr. Hinsdale, which could not be verified.

I append a table of all the operations I have been able to collect up to the present time.

REMARKS BY DR. MITCHELL.

After the final operation on October 18th, it was not until the latter part of December, just before his discharge from the hospital, that the patient's mental condition improved so much that a careful examination of the areas of sensation could be made. There was no absolute anæsthesia, except between the margins of the flap of this operation. Sensation to touch was everywhere else preserved in some slight degree. Pain sense was but slightly impaired as compared in the right infra-orbital region immediately about the scar of the operation upon the infra-orbital nerve, there was a small area which was hyperæsthetic.

When last seen, during the last week in December, I found that an area as large as a half dollar, with its center upon the outer third of the right eyebrow, covered a space which was hyperæsthetic to touch though not to pain, and this although he was unable to move voluntarily the muscles above the brow on this side.

Dr. K. has since returned to the hospital, reporting himself as continuing without any pain in the face, but one statement which he makes is certainly curious. During the cold weather when he goes out

he says that he feels as if he had two faces, one quite apart from the other; one of which, the left or normal side, felt the cold and the other did not.

When violent neuralgia marks out with lines of fire the course of superficial nerves, or when by operation we demonstrate the ramification of the tiny twigs to the skin and surface tissues, it is rather the rule than the exception to find some small anomaly in the distribution of the ultimate fibres, as compared with the topography described in the books. Physiological methods of tracing and mapping these nerves are needed, rather than those of the anatomist's dissecting table. In the case here described, the only anatomical peculiarity was the situation of a foramen more than an inch posterior to the mental foramen, giving exit to a nerve of some size, distributed thence on the tissues of the cheek. The foramen mentale was exceedingly small, and through it passed only a little twig, so slender as to make its discovery difficult and its recognition doubtful.

In another patient of mine upon whom Dr. Keen operated some years ago, a different difficulty was experienced in locating this opening. The patient, an elderly woman, had all her teeth removed. The gums and probably the alveolar processes had consequently atrophied, and the foramen was thus brought much nearer to the upper margin of the jaw than usual, and some search was needed before it could be found.

The regeneration that we so commonly find occurs in divided nerves when we do not want regeneration, followed the several nerve sections here, as in other cases. Such a frightful amount of pain teaches an opportune lesson of the desirability of deeper operations in the early course of trigeminal neuralgia. If the neuralgia persist, a neuritis almost inevitably follows, whether brought about by the same irritation which sets up the neuralgia, or, as I cannot but think often happens, set up *by* the neuralgia, the constant pain keeping the nerve over-stimulated and over-full of blood until it passes from active congestion into inflammation. A neuritis, however small, is a bad neighbor. We speak of ascending and of migratory neuritis; but every neuritis ascends and generally descends, too, though it may be only a small spread in either direction. But spread it will—and it is certainly astonishing when we consider the close connection between the nerves of the face and the great centres of life in the brain, that we so rarely see brain disease result from this form of nerve-inflammation.

At the origin of these cases some form of peripheral irritation is often to be found, but by no means constantly. The teeth are usually blamed, and one seldom sees an old case in which they have not been more or less completely removed—because, if they had not caused pain, they might cause pain. The seat of distress is often in a tooth, but do we not always find the sensation of pain referred to the periphery of the affected nerve? I have seen at least one case in which relief of pain that had persisted in spite of palliative operation, resulted from the application of a properly fitting denture. No doubt the restoration of a natural amount of pressure upon the gums and alveoli had something to do with this. In Dr. K.'s case the original cause was in a tooth and destructive processes in the alveolus.

Besides the pain which accompanies these neuralgias, various other troubles may result from the peripheral irritation. One of my patients had had one or two attacks of lesser epilepsy a month, always at her menstrual periods, up to her fiftieth year, when they ceased with the menopause. When several years later, she began to have the trigeminal neuralgia, they returned, and became much more frequent, coinciding with the sharper paroxysms of pain. They disappeared with Dr. Keen's resection of the offending nerve, and have never recurred.

The second and third divisions of the trifacial nerve are much oftener subject to the attacks of tic than the first. It is impossible to assign any reasons other than suppositions for this. The functional necessities of the face and eye require that the nerves which supply them shall be sensitive and acutely perceptive in the highest degree. This gives them a certain susceptibility. Then the position, especially of the second and third divisions, exposes them peculiarly to sources of external hurt, such as irritation, or even infection, from decayed teeth, injury from cold, or from substances taken into the mouth, acting through the lingual branch as well as through the dental filaments.

The ganglion removed has not yet been minutely studied. It certainly would seem reasonable to expect to find in the

centre, after over stimulation continued for so long a period of years, some signs of this excess of action in the nerve cells.

Hodge, in the admirable papers published in 1889 and 1891, upon exhaustion of nerve centres has pointed out the microscopic changes we may expect to find in tired and exhausted cells. They are so distinct that when once acquaintance has been made with them it is not difficult to say of two specimens, "This one came from an animal exhausted by muscular action; this one came from an animal in a healthy condition."

It has been supposed by some authors that the root of the malady lay in an atrophy of the ganglion; but were atrophy to be found, I would rather incline to regard it as a result than as the cause of the morbid condition of the nerve.

## PSEUDO-COXALGIA.*

J. K. MITCHELL, M. D., PHILADELPHIA.

There is not much to be said about hysterical coxalgia apart from its differential diagnosis from true hip disease. The symptoms very closely resemble each other. Hip disease is not a very common form of appearance of hysterical disease of joints. The condition which most often presents itself is hysterical knee-joint disease. I have seen in some years past but two or three cases of simulated coxalgia.

The two differential points on which I should be inclined to lay the most stress are first, that under proper means of examination, even without anæsthesia, motion would be freer than if real disease existed, but this is by no means always true, since often in hysterical troubles a considerable amount of exudate is thrown out about the joint. Secondly, the condition of the local temperature is important, although not positive. If the temperature of a joint, suspected of hysterical disease, be increased and yet there be nothing in the general condition to point to inflammation, this would be an important matter; but it must be said, as was originally, I think, pointed out by Sir James Paget, that if the local temperature be higher at night than in the morning, the case is not one of acute inflammation, but of simulated disease most likely hysterical.

Sometimes there is swelling in these cases, but even if there were neither heat nor swelling, one could not by the absence of these signs alone be certain as to the purely nervous nature of the trouble. I think I should be more inclined to lay stress upon the appearance of the hysterical stigmata, such as tenderness in the spine, ovarian tenderness in females, photophobia, general hysterical manifestations, narrowing of the fields of vision, or changes in the color fields.

As to this later point, Dr. de Schweinitz and I, in a recent investigation, have found so few cases even in typical instances of major hysteria, where the color fields were altered, that it has made me doubt whether the statements, made by the French authors, as to the frequency of occurrence of this change in the eyes, are equally true for this country.

Besides this, in a majority of cases of hysterical disorder, we shall find uterine symptoms and marked tendency to constipation. Perhaps I might mention as a very interesting case of knee-joint disease, in which there was great difficulty in making a diagnosis, one which has already been reported by Dr. Weir Mitchell in his Lectures on Nervous Diseases. The late Dr. Sands, of New York, saw the case early when the joint was much enlarged and quite disabled. His opinion—and we all know it was one entitled to every respect—was that the swelling was entirely outside of the joint proper. Dr. Weir Mitchell saw the girl in consultation, and was also convinced that the case was a hysterical one. The patient, however, went abroad and, in Vienna, was seen by Dr. Billroth and by Dr. Nothnagel, who both were quite certain that the joint proper was diseased, and Billroth went so far as to say that if operation were done the cartilage would be found eroded. On the strength of this judgment, Dr. Sands, with considerable misgivings, opened the joint and found it absolutely normal as to its cartilaginous surface. The swelling which was present was altogether outside of the capsule, and consisted of a brawny thickening of the skin and sub-cutaneous tissues. He closed his wound carefully, and the enlargement, in the course of time, entirely disappeared under general treatment and the patient recovered perfect motion.

*Read before Sec. Orthopedic Surgery, College of Physicians, Feb. 17, 1894.

# SARCOMATOUS OR OTHER TUMORS WHICH MAY, IN THE EARLY STAGES, BE CONFOUNDED WITH HIP DISEASE.*

DEFOREST WILLARD, M. D., PHILADELPHIA.

Certain tumors originating in the region of the hip-joint, when accompanied by pain in their inception, may easily be mistaken for tubercular bone disease. I can recall but one or two such cases in children, but in adults I have seen a number which have been diagnosed as hip disease before their characteristics were distinct.

A physician who first sees such a case is always at a disadvantage in regard to diagnosis. In children, especially, the history will be very similar to that of tubercular hip-joint disease. A slight blow apparently arouses the disease; then follows pain with increasing limp, tenderness, slight fullness, thickening about the articulation, above or below it, slight limitation of motion in the direction opposite to the side upon which the mass originated; these are the symptoms which would naturally lead one to infer that the more common disease of tubercular ostitis exists rather than the rarer one of sarcoma. An experienced orthopedic surgeon, however, will at once recognize that this partial limitation of motion is frequently found in exceptional cases of tubercular lesion.

Moreover, pain, which increases with the growth of a sarcomatous tumor, is a very constant symptom in the tubercular form; consequently, as I have said, any man is excusable for a mistaken diagnosis in the first few weeks of sarcomatous disease. As the growth proceeds, it is apt to become more localized, that is, its projection is a firm hardened mass in a certain direction, usually anteriorly; while in the tubercular variety, the thickening is more diffused over the region of the joint.

The tumor may or may not be nodulated. Restriction of motion is positive in one direction, usually extension, while flexion is somewhat interfered with by the size of the growth. Tenderness is also limited to a small area, smaller than in the tubercular variety, pain but seldom extends down the inside of the thigh towards the knee. Flexion is usually present to a moderate degree. Abduction or adduction are rarely present. The buttock may be flattened and the ileo-femoral crease shortened as in tubercular hip disease. Instead of atrophy of the limb there is usually swelling or œdema.

During the latter stage the diagnosis is easy. The size, position and character of the swelling is sufficient to mark its nature. Pain, especially in adult cases, does not increase in proportion to the extent of the disease. In one case which I recall, the man suffered exceedingly for two months while the tumor was small, but was almost entirely free from pain during the remainder of its progress (over a year) when the tumor attained enormous proportions. In his case, while the greater portion of the tumor was hard, yet there was numerous cysts and fluctuating points the tapping of which might have been considered for the relief of pain had not the symptoms ceased to be violent.

In one or two other cases which I recall, the cessation of pain, as the disease progressed, was very marked. In one case, already alluded to, the tumor apparently sprung from the periosteum of the neck of the femur, possibly from the bone above the articulation. It had advanced too far before it was noticed, for any operative procedures to give relief, and death occurred from exhaustion. I did not see the case during the early stage, but the history was somewhat similar to that of joint disease; a slight injury, pain after a long walk or after standing, increased shortening of the limb, and gradual interference with the function.

I have a case now under my care which presents very similar symptoms, and yet I believe it to be an early stage of tubercular hip disease in the adult; another case, which is very similar, I believe to be rheumatoid arthritis, and yet I do not accuse myself of ignorance in being unable to positively fix the diagnosis at the first visit. Time alone can solve the problem.

I have a young man under treatment whose difficulty I have recorded tubercu-

*Read before Sec. Orthopedic Surgery, College of Physicians, Feb. 17, 1894.

lar, and yet I have a strong suspicion, on account of the local character of the projection, that it is sarcomatous disease in process of development.

Another case is that of a man forty-five years of age whom I saw in consultation. I found no difficulty in diagnosing sarcoma, although it had been treated for many months, by experienced surgeons, for tubercular trouble. It is no credit to a surgeon who is called in at the late stage to decide as to the character of the tumor.

I saw, still another man past sixty, a consultation case, in whom the pain had been atrocious, but which diminished gradually after the compact tissue of the ilium had yielded sufficiently to permit easy expansion. He had been treated also for many months for hip disease.

I saw to-day, a case of possible malignant disease, in a man thirty years of age, but as there was a history of a year of pain which was characterized as starting at night, and as there was a large but evenly distributed induration about the hip, marked with flexion and abduction, I am strongly inclined to consider it as a case of ordinary hip disease rather than that of commencing tumor.

In another instance where I was called in the country to see a case of hip disease which had existed for many months, a hardened nodulous tumor arose distinctly from the region in front of the trochanter and had attained the size of a child's head. The early history had mislead the attending physician, and as is not infrequently the case, had biased his opinion even when decided sarcomatous appearances were marked later.

Every physician frequently finds himself placed at a disadvantage. Relying upon his first diagnosis, and perhaps relaxing his vigilance, or perhaps failing to re-examine the case for some weeks, he will find, during a more thorough examination, conditions entirely different from those which existed a month previous. Such situations are unpleasant, and are nearly always due to insufficient care; not infrequently to insufficient exposure of the part. I am daily more and more convinced that a large proportion of errors in diagnosis would be avoided if the naked body could be observed and a comparison of the two sides noted.

Sarcomas in this region are usually very malignant in their character. Their growth is slow until rupture takes place, after which rapid dissemination is the rule, with quite possible metastases. The cysts are apparently due to the liquidation of the tumor elements, or to extravasation of blood and serum. Tapping of the cysts is inadvisable except when the pain becomes very great, as protrusion of the mass with hemorrhage follows. In some cases the great vascularity of the tumor with its pulsation may similate aneurism, especially the central round cell sarcomata, the medullary or hematoid cancers.

Few of these tumors are suspected from the beginning and only occasionally is it possible to recognize them early. In order to do this the entire group of symptoms must be surveyed, not merely one particular symptom. In the majority of cases it will be found that although one or two, or perhaps half a dozen symptoms indicate tubercular trouble, yet one or more important symptoms are absent. It requires, therefore, careful sifting of all the evidence, and close observation, as a safe guard against error.

Sarcoma, as a rule, especially in children, is of rapid growth and ordinarily accompanied by severe pain in the early stage. In my experience, in adults, it springs frequently from the ilium rather than from the femur, and these cases are incapable of being benefited by operative procedures. Sarcoma is much more common than carcinoma in this region. The central growths are ordinarily of the giant cell variety.

Suppuration, in my experience, is rare; in fact, I do not recall an instance in which it has occurred. The patient usually dies from exhaustion, or from systemic infection, or a blood vessel transference of the disease or some other organ, even before rupture of the skin and hemorrhagic protrusion of the contents take place. When suppuration does occur, I believe that it usually arises from other inflammatory elements—probably traumatic.

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THE corset is a waist basket. It is also a waste basket in wasting health, vigor and vitality.

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**Something Easy.**

Waiter—"De usual steak, sah?"

Regular Customer—"No; I am tired tonight. Bring me a plate of hash."—*Indianapolis Journal.*

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### INFLUENZA, BRONCHITIS AND BRONCHO-PNEUMONIA.

In *Revista Clinica Terapeutica* (No. 12, 1893) the sulphate of codeine is recommended, in the treatment of the grippe, bronchitis and broncho-pneumonia, in the following formula:

℞ Salicylate of Cinconidine.
Hydrate of Terpene,....āā 18-30 (grs. ijss-v).
Sulphate of Codeine,....5-75 mgms. (1-13 to 1 1-16 grs. gms).

Sufficient for one capsule. Make twenty such capsule. One every 2-4 hours.

### ACETANILID AND DOVER'S POWDER IN GRIPPE.

Dr. E. Graetzer (*Wiener Medizinische Presse,* No. 6, 1894), in the treatment of the grippe recommends a combination of Dover's powder and acetanilid which he has employed, with the best results:

℞ Acetanilid..... 25 cgms. (grs. iv).
Dover's Powder..... 15 cgm. (grs. ijss).

One powder three times a day.

### PERMANGANATE OF POTASH IN ACUTE POISONING BY PHOSPHORUS.

Dr. Adolf Kelemen (*Pester Med. Chirurgische Presse*, No. 3, 1894) in support of the efficacy the permanganate of potash as an antidote in poisoning by phosphorus, reports the following case: A peasant woman of fifty-four years, dissolved the heads of four packages of matches in water and drank the solution, at eleven o'clock in the morning. The writer was called at half past two in the afternoon, when he found her in bed restless and continuously vomiting. Her gastric region was painful, her face pale, her pulse rapid and full. He had brought with him two quarts of a 1 per cent. solution of the permanganate which he had her drink by the glass full every three to four minutes. Within two hours she drank over a quart of the solution and vomited twice. He then left the patient, with instructions to drink the remainder. The next day she complained of violent pains in the stomach and had vomited three times. He ordered another quart of the solution to be drunk. For three days the gastric pains continued and coagulated blood was found in the vomit. As a beverage she received albumen water. From the fourth day the pains decreased in intensity, the vomiting did not reappear and her general condition so improved that she could be regarded as cured. The writer has observed several cases of poisoning by phosphorus, yet this is the only recovery that he has known. As all others ended fatally he can only ascribe the result to the permanganate.

### MASSAGE IN INTESTINAL INCARCERATION IN CHILDREN.

Dr. Maiss (*La Semaine Medicale*, No. 72, 1893), treated a child of nine months who after an attack of indigestion was seized with symptoms of obstruction. A sausage-like tumor was found in the region of the descending colon which extended into the left iliac fossa. In spite of large doses of opium the condition of the patient became worse and a laparotomy seemed indicated, but before operating he tried massage. With the pelvis elevated the right hand was placed over the iliac tumor, thus fixing it, while with the left hand the lumbar region was compressed. The tumor was then pushed upwards towards the diaphragm and immobilized and effleurage done from left to right. After a few such movements, with deep pressure, the tumor together with all the symptoms of occlusion, disappeared. Dr. Barder, in the same journal, records two other cases. The first was a child fifteen days of age, where opium and intestinal irrigation were without effect. By bimanual examination he was able to make out a cylindrical body, seven to eight cms. in length, which lay obliquely in the left hypochondrium; invagination of the colon in the ileum. A few frictions with the right hand, from left to right, produced a marked relief. A second and more energetic massage caused the tumor and the symptoms to disappear. The third case was that of a girl of eighteen months, who had suffered for several days from diarrhœa and who was seized with symptoms of incarceration after an attack of coughing. In

*In charge of the translator, F. H. Pritchard, A. M., M. D.

the left iliac fossa a sausage-shaped swelling could be outlined through the abdominal wall. A few seances of massage, with the little finger of the left hand in the rectum and with the right hand pressing on the tumor, gradually caused it to disappear.

### QUININE IN INFLUENZA.

Dr. Graeser (*Wiener Medizinische Presse*, No. 3, 1894), has employed quinine in the epidemic of 1889-90, in the Poliklinik at Bonn, and claims that the patients thus treated suffered less from after-effects of the disease. Only three reappeared for treatment the second time, while of those who received other remedies over half came the second or third time. The depression and feeling of tiredness were of much shorter duration than those under other treatments. It was also employed prophylactically. In Bonn the soldiers of a regiment received seven and a half grains of the sulphate in half an ounce of whiskey every day for twenty-two days. Though some fell sick, fewer were attacked than in other regiments or in another in the same garrison. From his experiments he regards quinine as a specific in influenza.

### PETROLEUM IN CANCER AND VAGINITIS.

Dr. Desprès (*Centralblatt fur Gynækologie*, No. 48, 1893), recommends ordinary refined coal oil in the treatment of cancer and vaginitis. In ordinary inoperable carcinoma of the uterus he injects it into the tumor and applies it on tampons in the vagina or uses it in irrigations. Injected into abscesses it causes healing to take place, removes the disagreeable odor of disintegrating carcinomata, especially of the uterus, causes the gangrenous surfaces to be cast off and the ulcerations to become dry. In vaginitis he has also employed it with success as injections and claims that after three daily injections of four to five ounces of the oil, a cure will be obtained in six days. Petroleum has the advantage of easily diffusing itself, deodorizing and disinfecting and yet not irritating the mucous membranes. If applied to an already inflamed mucous membrane it has caused vesicles to form. The patients did not complain of the odor nor was their general health affected.

### QUININE IN WHOOPING COUGH.

Dr. P. Baron (*Wiener Medizinische Presse*, No. 3, 1894), has tried quinine in fifty cases of whooping cough and is well satisfied with the results. In a few of the children a favorable result was observed at once, especially on the second to third day. But in the majority the results were varying for several days, as they were inclined to vomit and unequal quantities of the drug were absorbed. The stage when the drug is administered has quite an influence. From the fifth to the sixth day a decided improvement as to the number and severity of the attacks may be relied upon. When improvement has once set in it still will continue even if the remedy be given in smaller doses. On an average three weeks were required to effect a cure; in some cases the action is actually abortive. No relapses. It is especially valuable in cases accompanied by acute pulmonary affections. The single dose is one-fifth of a grain per month and one and a half grain per year, of the child's age, three times a day. It is best given in the morning at six, in the afternoon at two, and in the evening at ten o'clock. More than three doses per diem, or six grains, for children over four years is not necessary. If improvement has set in distinctly then do not give more than two daily doses, then decrease it gradually and after nearly complete recovery, let them take a dose in the evening. If the appetite is deficient prescribe hydrochloric acid.

### NEURALGIC DYSMENORRHŒA.

In the *Rivista Clinica e Terapeutica*, No. 12, 1893, the following formula is spoken highly of in neuralgic dysmenorrhœa:

℞ Extract opium.....10 cgms (grs jss)
Extract belladonna.....10 cgms (grs. jss)
Sulphate of quinine.....1½ gms (grs xxijss)
Sufficient for twenty-five pills. One every three hours.

### SACCHARATED SOLUTION OF IRON AND MANGANESE.

In the *Union Médicale*, No. 49, 1893, the following formula is presented:

℞ Saccharated oxide of iron.....200 gms (℥vjss)
Distilled water.....700 gms (℥xxjjss)
Crystallized chloride of manganese 3.7 gms (grs. xlv).

Dissolve the iron in the other two constituents, then add:

Distilled water..... .....15 gms (3iv)
Sol. citrate of ammonia..... 25 gms (3vj)
Alcohol.. .. .....50 gms (3jss)
Tint. orange peel..... 3 gms (gtts. xlv)
Tinct. vanillia..... 1 gm (gtts xv)
Acetic ether.....gtts. v.

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ICHTHYOL IN ACUTE OTITIS MEDIA.

Dr. Solt (*Gazetta Degli Ospitali*, No. 150, 1893), on account of the good results which have been obtained in metritis with ichthyol, has tried it in acute otitis media. He advises the following formula:

℞ Ichthyol.....1 gm (grs. xv)
Glycerine..... .....
Distilled water, āā.....7½ gms (3ij)

Drop a few drops of this mixture into the meatus three times a day.

He claims that it exercises a very favorple result in acute otitis media. The pains cease rapidly and the inflammatory symptoms gradually disappear.

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CASTOR OIL ADMINISTERED AGREEABLY.

In the *Gazette Degli Ospitali*, No. 150, 1893, it is asserted that if one shake a mixture of castor oil in warm milk, in a bottle, an agreeable emulsion is obtained. The disagreeable odor and taste are thereby masked.

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TREATMENT OF HEADACHE IN CHLOROTIC PATIENTS.

Dr. Albert Robin (*Gazette des Hopitaux*, No. 10, 1894), advises the following formulæ in the treatment of the headache of chlorotic subjects:

℞ Powdered paullinia.....20 cgms. (grs. iij).
Extract of cannabis indica..... 1 cgm. (gr. jss).

Sufficient for one pill. Three pills a day.

℞ Antipyrine .....50 cgms. (grs. vijss).
Mur. cocaine.....1 " (grs. jss).
Caffeine.....1 " (grs. jss).
Bromide ammonia.....50 " (grs. vijss)
Iodide ammonia.....50 " (grs. vijss).

Sufficient for one powder. One per diem.

℞ Phenacetine.....25-50 cgms. (grs. iv-vijss).
Exalgine.....10-15-25 " (grs. jss-ijss-iv).

Sufficient for one powder. Two per diem.

Ferrous preparations may be tried, but the results are variable. Menthol externally may be of service.

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HYDRASTININE IN EPILEPSY.

Dr. Kisselew (*Le Mercredi Medical*, No. 51, 1893) on account of the anti-convulsive action which he has observed hydrastinine to exercise on animals, has tried it in epilepsy. It was administered internally in a watery solution, in a dose of one to two cgms. (1-6—1-4 gr.) and five doses, per diem. In all he gave it to four patients. In two the result was negative, while in the other two, after two or three weeks of treatment, there was a remarkable diminution, both in the intensity and frequency of the attacks. No inconvenience was observed from its use.

---

MANY people cannot understand why the small pox at present continues to crop up in new localities, and seems unconquerable. One of the reasons is to be found in the ignorance and turpitude of the tenement-house population, especially among the recently-arrived Italians. One of the special inspectors appointed by Dr. Doty to look out for suspicious cases, was directed by a policeman to a tenement in Mott street, on February 25th. The inspector found the doors to the room on the top floor locked and barred. Threats to arrest the inmates had no effect, and finally the doors were broken in. A search of the rooms revealed no sick person, but just as the doctor was leaving he heard some one sneeze. The sneeze seemed to come from a big trunk in the corner, and lifting the lid, he found an Italian boy beneath some bedding. The boy was covered with the eruption of small pox, and had been sick five days, and had no medical attendance. On the floor below, where also the doors had to to be broken in, there were two children hidden away. One had been attacked twenty days ago, and was now recovering; the other, a girl, four years old, was very ill of the disease. This tenement shelters twenty-five families, of Irish and Chinese, and, of course, a corps of officers was at once set to work searching all the tenements in the neighborhood and vaccinating the occupants. In a tenement in West thirty-sixth street, no less than five cases were found, and the officials were not resisted, it was found that though the two families affected many other persons had been exposed. It is plain that nothing but the constant vigilance and actual vaccinating work of Dr. Doty's men saved us from a wide diffusion of the disease.—(*Ind.*)

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SATURDAY, MARCH 24, 1894.


## EDITORIAL.

### TREATING PULMONARY TUBERCULOSIS WITH TUBERCULIN.

In a paper read before the Climatological Society, last May, by Dr. Karl von Ruck, Koch's tuberculin was shown to possess curative properties greater than has recently been attributed to it. Twenty-five cases that had been treated with it were reported. These were divided into three classes: *Class A*, included three patients, "who had one or both upper lobes involved, but without destructive changes, the general health of these patients being comparatively good." *Class B.* Patients "with more extensive disease or moderate destructive processes, but still in a fair physical condition." *Class C.* Cases "still further advanced in local disease, with considerable constitutional impairment, but still in a condition justifying some hope of improvement." In class *A*, five patients were treated and all recovered. In class *B*, seven cases were treated, of which six recovered and one was improved. There were thirteen belonging to class *C*, of which seven died and six were improved and still living.

Much of this success is attributed to the method of administering the tuberculin. The initial dose used by von Ruck was 1-20 milligram and the quantity was gradually increased by tenths of a milligram until one milligram was given. Then the increase was by fifths up to two milligrams; then by halves up to ten; by doses of two and a half milligrams up to twenty; and thereafter by doses of five milligrams at a time. Periods were observed when for weeks together no local or general reaction was observed, while the improvement of the patient progressed favorably; and whenever a point had been reached where this improvement was radical and active symptoms had entirely subsided, the administration ceased, allowing an intermission of from two weeks to a month. If no relapse had occurred in this time, if every symptom and indication was favorable, the patient was kept under observation. If the result was not satisfactory a repetition of the treatment was necessary.

In the second course the initial dose was

1-10 milligram, but increased after each dose so long as no local reaction occurred.

These results are encouraging, but the fact should be borne constantly in mind that it is in the early stages of the disease that the greatest benefit was received. The practical importance of this is the necessity for early diagnosis, a fact well known to all physicians, but often neglected until the disease has advanced so far that the diagnosis is evident from the advanced lesions produced. Again the fact should not be overlooked that von Ruck had the benefit of excellent climate and the perfect control of his patients which he himself admits were valuable adjuncts.

However, his results are encouraging and the evidence quite conclusive that much benefit was obtained by the use of tuberculin.

## STERILIZING MILK AT A TEMPERATURE OF 75° C.

Freeman (*Med. Rec.*, June 10, 1893), has contributed an article of much interest on the sterilization of milk at a temperature of 75° C. (167° F.). This is known as *pasteurization* of milk.

The method formerly employed to sterilize milk was to heat it to a temperature of 100° C. (212° F.)—or to the boiling point. This process was found to produce many changes in the milk which renders it less digestible. The casein is rendered less coagulable by rennet, and is acted on slowly and imperfectly by pepsin and pancreatin. Milk sugar is destroyed.

Pasteurization, however, furnishes a food which is practically sterile during the ensuing twenty-four to forty-eight hours; a food on which infants seem to thrive, and which has undergone practically no modification from heat. Milk prepared in this way is not intended for keeping several days but should be prepared daily.

The author had repeated many of the experiments to determine the thermal death point of certain pathogenic bacteria which may find their way into milk. His conclusions are as follows:

1. "Pasteurization of milk at about 75° C. affords a safe guard against deleterious effects of any bacteria which it may contain, without interfering with its nutritive qualities.

2. "Pasteurization at about 75° C. (167°F.) destroys efficiently the germs of cholera, typhoid fever, diphtheria, and tuberculosis, as well as the streptococcus pyogenes, the staphylococcus pyogenes aureus, and the bacillus coli communis."

3. "Pasteurization at about 75° C. does not modify the size of the curd formed when milk is subjected to the action of the gastric juice."

4. "Milk after pasteurization is best cooled in a water bath."

5. "Pasteurization at about 75° C., may be used after peptonizing to stop the action of the ferment."

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THE crusade of the State Boards of Health against quacks, brings to light some queer characters, and presents a melancholy spectacle of dupes who pour money into the pockets of these unprincipled harpies. At one of the meetings of the State Medical Society of Missouri, an account was given of an old impostor in the northern part of the State who claimed to have wrought miracles of healing "with only three remedies," all from a certain root. *Highbobalorum* was obtained by peeling the root upward, and was a certain emetic. *Lobobalorum* was obtained by peeling the same root *downward*, and was a sure cathartic; and *Hilobustem*, by peeling the root around, was a rank poison and would carry everything before it was only to be used when the others had failed.—*N. Y. Med.*

## PROTOZOA AND CARCINOMA.

There is probably no subject in pathology over which there is more earnest controversy than the etiology of cancer. That cancer is due to the presence of a protozoan, has been positively asserted by certain investigators, while others maintain that it is not of parasitic origin.

Adler (*Amer. Jour. Med. Sci.* Jan. 1894.) gives the results of his study of cancer, in which the adherents of the protozoan theory can not find pleasure. He has studied the subject for over three years, has used many methods of investigation, and has examined over 60 cancers from different parts of the body.

After a careful discussion of the subject he draws the following conclusions:

"The existence of parastic protozoa in cancer is probable, though the greater part of what has hitherto been described as parasitic is certainly not so. No constant or in any way specific organism has as yet been demonstrated beyond possibilities of doubt. At present no facts, histological or otherwise, compel the asumption of a parasitic origin of carcinoma, while there are very strong and valid arguments against such assumption."

# ABSTRACTS.

## TWO CASES OF HERNIA OF THE FALLOPIAN TUBE.

Dr. Morton reports a case of a woman, forty-six years of age, who sought advice at the out-patient department of the Royal Surrey County Hospital, on account of a swelling in the right groin. She had had a swelling there constantly for two years, and it had suddenly become larger five days before she attended the hospital. There had been no action of the bowel for five days. The swelling was tender to the touch and gave impression of an inflamed gland softening in the centre.

A simple enema was administered, and produced a considerable evacuation. Four days later an incision was made over the swelling through tissues which were of almost cartilaginous density. This exposed a rounded, grey, translucent mass, which looked almost like the colon, but was in reality the thickened sac. On opening the sac, a small quantity of coffee-colored fluid escaped. The sac contained some omentum and an irregular, varicose-looking mass, attached to one end of which were some congested papillary projections. These latter proved to be the Fallopian tube and its fimbriated extremity. The tube and omentum were returned and the sac was ligatured and cut away. The wound healed by first intention.

*Case 2.*—A woman was admitted to the Royal Surrey County Hospital suffering from a strangulated right femoral hernia, which had been down for five weeks. The symptoms of strangulation were of a fortnight's duration. A simple enema produced a copious evacuation, and this was followed by a copious natural evacuation some hours later. Herniotomy was performed and the sac was found to contain gangrenous omentum and gangrenous ruptured bowel. The peritoneal cavity contained a large amount of fæcal matter apparently mixed with pus.

The gangrenous omentum was removed, and an artificial anus made, but the patient died from shock twelve hours later.

At the post-mortem examination the bowel was found to be ruptured about eighteen inches above the ileo-cæcal valve. The omentum, small intestine, and cæcum were all much matted together, and glued to the surface of the mass so formed was the end of the right Fallopian tube, which was gangrenous to the extent of about half an inch, having evidently been caught in the constricting band. The vermiform appendix was apparently healthy, although the finding of an orange pip in the peritoneal cavity had given rise to a suspicion that the appendix might also be involved. —*The Lancet*, 1894.

# SOCIETY REPORTS.

## SECTION ON ORTHOPEDIC SURGERY OF THE COLLEGE OF PHYSICIANS OF PHILADEDPHIA.

*February* 17, 1894.

[Stenographically Reported by C. C. Mapes, M. D.]

DR. DEFOREST Williard opened the meeting by reading a paper upon "Sarcomatous or other tumors, which may in their early stages be confounded with hip disease." (See page 424)

### DISCUSSION.

DR. G. G. DAVIS: I do not remember having seen a case of sarcoma of the hip, but I recall two cases of tubercular disease in one of which an enlargement occurred above the trochanter and was supposed to be sarcomatous. It was operated upon and proved to be a collection of pus which had originated within the pelvis and come out of the greater sacro-sciatic notch. The swelling was the size of a small egg and being in that position and covered with muscle, it was difficult to be positive that fluctuation was present. I have seen, also, another case in which pus came from the same opening. The collection of pus arose from carious bone and worked its way downward and outward through the notch, and gave rise to the suspicion of tumor. A collection of pus so close to the hip joint might very readily give rise to a diagnosis of hip joint disease.

DR. T. S. K. MORTON; I have nothing to add to the presence of growths about the hip joint, but in thinking this matter over I recall a case of carcinoma of one mammæ, in a woman about forty years of age, which I saw several years ago. Some eight to ten months afterward she tripped when walking, and had a very slight fall to the floor which resulted in fracture of the neck of the thigh bone, and she died from shock. At the post-mortem was found metastasis of soft carcinoma throughout the body. The point of interest was the great destruction of the neck of the femur; it was almost replaced by soft carcinoma which left a thin shell of bone, so thin, that slight traumatism was sufficient to break it.

DR. BENJAMIN LEE: I have nothing to add to the history of such cases; judging from my own experience I should presume them to be extremely rare in comparison with tubercular disease of the hip joint. In regard to diagnosis I am of the some opinion as Dr. Willard. I should not expect these affections to have the same history as true hip joint disease; that is, to say, commencing with lengthening and eversion and going on to shortening and inversion. I presume that before such change could take place, the tumor would declare itself by its own characteristics. Another point of difference would be the absence of the starting pains, so characteristic of hip disease. One remark made by the author of the paper impressed me very much; and that was that in making his examination of these cases he had taken the pains to strip the patient so that the two sides could be compared, on this point I think we cannot insist on too strongly. I believe that the reason that the family physician often makes a mistake, and has to call upon an orthopedic surgeon for counsel is simply because he has neglected to make an examination, as Dr. Willard suggests, with the naked body before him. This should always be done, especially in suspected lateral curvature or hip disease; I consider it of the greatest importance.

DR. DEFOREST WILLARD: I have been called to the country twice this week in consultation, and in each case the physician could have made the diagnosis as well as I, if he had simply stripped his patient.

I remember a peculiar case on which Dr. Agnew operated for sarcoma of the breast. In twelve or fifteen months there was a return of the disease in numerous regions of the body. Both humerii were broken by very slight movement; one finger was snapped by being caught in the sheet of the bed and the other while being laid across her breast. Absolute union took place without any difficulty. The disease was progressive and she died a few months afterward. At the post-mortem was found a good callus, and no sarcomatous disease at the line of the fracture. It is interesting that in spite of the fragility of the bones, good union had taken place.

DR. F. SAVARY PEARCE: I recall no cases in the Orthopedic Hospital during my residency, of tumor of the hip, but I remember one of the upper middle third of the femur; it developed rapidly and had a fatal termination. The tumor was diagnosed sarcoma and was probably secondary to a malignant breast growth, removed some months previous. The woman was past middle life.

DR. G. G. Davis: I would like to ask Dr. Willard if he regards the condition as malignant disease of the humerii, or simply one of atrophy caused by the general dyscrasia. Cases of fracture occurring in malignant—particularly sarcomatous—diseases are not uncommon, but I would like to ask if this particular case was locally sarcomatous.

DR. DEFOREST WILLARD: I do not think there was sarcoma at the particular point which gave way. I believe the bones were fragile from the general condition, although there were probably twenty sarcomatous foci in other regions of the body.

There is no difficulty in diagnosing these cases in the later stages; it is in their beginning that a differential diagnosis is difficult to establish. I never saw starting pains in this condition. The pain is continuous and very severe with atrocious exacerbations, Starting pains make a very good diagnostic point.

DR. F. SAVARY PEARCE: A differential diagnosis must be made between malignant and simply ulcerated growths, and this is sometimes difficult. I heard of a case operated upon by Dr. Agnew who was misled by a large fatty tumor about the hip. The growth had ulcerated on the surface and a section was made for microscopical examination. It was reported malignant and the limb was amputated with a fatal result. Ulceration had occured over the growth which was a simple lipoma as stated. In this case the microscopist was at fault, not the operator.

"SARCOMA OF THE THIGH."

Presented by Dr. J. T. Rugh by invitation.

The case is one belonging to the Orthopedic Department of Jefferson Medical College Hospital, under the care of Prof. H. Augustus Wilson, and is extremely rare and interesting.

While there is no contra-indication to the development of sarcoma in hip joint disease, yet such a condition has seldom, if, indeed, ever been reported.

The history is as follows: W. W., aet. 19 years, born in Austria, and living in this country for the past two years. Family history good, personal history good until 15 years of age, when he fell striking heavily upon his right hip. The parts were quite sore for a few days but no special attention was given to the injury. In a few weeks pain and soreness developed and difficulty in walking was soon experienced.

These symptoms continued for several months, with occasional intermissions until the tenderness became extreme and enlargement of the part was observed; which gradually increased until one year from the receipt of the fall, an abscess ruptured on the posterior surface of the thigh and discharged very freely. Relief followed but the sinus remained patulous and in the next two years, or until January 31st, 1893, four new ones were formed. At this time he first came to the clinic and was admitted to the ward of the Hospital. Another abscess formed and an operation was deemed necessary. The bony involvement was evidently very great. On February 2nd, 1893, Prof. Wilson opened the part freely on the external surface just over the large trochanter and removed considerable dead bone. He also evacuated several pockets of pus. The acetabulum was extensively involved but was not disturbed. Drainage was obtained by rubber tubes, the wounded closed, and the usual dressings applied. Tubes removed in three days and parts dressed twice a day while in the ward. He was discharged on April 6th., 1893, very much improved in weight and strength. He has been dressed two or three times a week ever since.

In the latter part of December, 1893, a slight swelling appeared about 1½ inches below Pouparts ligament, extending downward and inward across the large vessels. This gradually increased and by the end of the first week in January, 1894, the circulation become hindered because of the situation and enlargement of the tumor. A week later flucuation could be detected at several points but it lacked the elastic and expansive feel of the true abscess, and was more like a transmuscular wave; but on account of the pre-existing ostitis, the rapidity of development and fluctuation, an abscess was diagnosticated by all who examined it. There were also enlarged veins; œdema (slight over the tumor but marked below it); no elevation of the temperature, no pain, no soreness, and no heat or redness.

On January 27th., 1894, Dr. Mann and I opened it in two places but found no pus. The finger introduced into the wound detected very soft, friable, and easily detached tissue. Hemorrhage was very profuse. Some separated pieces were examined and thought to be sarcomatous, both from appearance and feel. Closure of the wound stopped the hemorrhage and dressings were applied.

Sections of the tumor were made and examined by Prof. Coplin and Dr. Kyle but neither would say positively that it was sarcoma, yet both agreed that it had more the characteristics of such than of inflammatory tissue which it resembled.

The clinical history is plainly that of sarcoma for the list of local and constitutional symptoms entailed in the production of so extensive an inflammatory exudate are all absent. On Feb. 13th, when I removed the dressings, a large fungating mass existed at one of the incisions from which quite a

stream of blood flowed. The mass was about 1½ inches in diameter and was raised about ½ inch above the skin. The origin is very doubtful as there are many structures from which it might arise, but the probability is that it is of bony origin though it may be from the connective tissue of some old sinus, and caused by some irritative impression of the tubercular ostitis.

Removal of the growth would be impossible because of its size and situation. Amputation is also negatived by the widespread tubercular infiltration which exists. Comfort only can be offered though not insured.

(The patient was then brought in and examined by all present. Sections of the tumor were also shown with the microscope.)

DISCUSSION.

DR. J. K. YOUNG: This case should not be allowed to pass without some discussion, yet there is very little to be said. The opinion given by the pathologists is one that we often hear. My experience with pathologists has been very unsatisfactory, and I prefer to rely upon the clinical history and appearance. My opinion is that very little can be told by pathologists as to the character of a specimen until the death of the patient or the entire tumor is removed. This was particularly noticeable in a recent case in which the pathologists gave a report that it was malignant, but which was reversed upon more thorough examination. There are only two symptoms in the present case which point to its being benign. The growth appears to have occurred in the cicatrix of one of the sinuses, in the interior portion of a groin. It will probably be found that the femur had been the starting point. Fungoid tumors about the sinus are not uncommon and they have the characteristic appearance spoken of by Paget. The position of this sinus and the character of the growth would indicate the femur as the part involved. If in this case the tumor be benign, the bleeding and the œdema might be due to pressure upon the femoral vein. The great size would indicate a mass of granulated tissue in the capsule.

DR. G. G. DAVIS: This condition interests me because if it is sarcomatons it shows the co-existence of two diseases in the same neighborhood, and both of them marked ones. The sinuses are not all closed; there are four open ones, all discharging, and there must be active disease going on somewhere. The presence of active bone disease and active malignant disease in the same vicinity, both pursuing a marked course, is, I think, unlikely. Should it be the two diseases, it is most remarkable. I should not be willing to make a diagnosis without some hesitancy, and yet I would not be surprised at a pathologist making a diagnosis of malignant disease from the granulations surrounding the opening. I think there is at least some room for doubt as to the affection being malignant.

Dr. Mitchell has just made a suggestion as to the original disease having been malignant instead of tuberculous. I do not think this can be the case as the tubercular disease has existed for three years and pursued a steady course of clinical bone disease, and we know that sarcoma has no tendency to suppuration, and therefore I do not think that the primary disease was sarcomatous.

DR. DEFOREST WILLARD: The possibility of the disease having been sarcomatous from the first also occurred to me, but the clinical history is so characteristic of bone disease that the diagnosis seems very clear. I should rate it a tubercular ostitis. But its present condition I should not hesitate, however, to call a sarcomatous growth. It is an unusual case, I have never seen one like it. It is probably a sarcomatous disease which has become engrafted upon the cicatrix. There is nothing incompatible in the co-existence of the two diseases; it is altogether possible. In this case I do not think we can take any exception to the diagnosis made. The course will probably be rapid from this time.

DR. T. J. RUGH: There is one point to which I should like to call the attention of the section and that is in regard to the microscopical examination. The part for section was taken from the centre of the tumor itself. The tumor had not been opened until it had been opened by the knife. The point upon which the pathologists were in doubt was the condition of the blood vessels, which are thoroughly characteristic in inflammatory tumors, that is, the walls are thickened and enlarged, while in sarcomatous growths the blood vessels have no walls. In this specimen they found, in some parts, thickened walls; in other parts, none. That is my reason for the statement that they would not affirm or deny in favor of sarcoma.

DR. J. K. MITCHELL: It seems to me that the question of tuberculosis might readily be disposed of by the microscope or by cultivation.

DR. J. T. RUGH: I did not tell the pathologists from what part of the body the specimen was taken, nor anything of the clinical history, and their reports were based entirely upon the microscopical examination.

DR. SAVARY PEARCE: The talk seems to have drifted into the difference between *macroscopic* tubercular and sarcomatous conditions. *Microscopically* ulceration and sarcoma are allied. In October last I removed a breast from a case of my father's which had all

the appearance of malignant disease and was fungoid in character. The patient was a woman fifty-two years of age. There was no enlargement of the lymphatic glands. The pathologist who examined the specimen thought it sarcomatous; my father supposed it to be carcinomatous. At a meeting of the Pathological Society, a section was shown to Prof. Guiteras, who decided it to be intercanalicular-fibroma. The wound healed by first intention. The woman is now well. I speak of this because the difference in opinion of pathologists in diagnosing tumors is explained by the position of the different sections.

The round celled infiltration of ulceration can easily be mistaken for small round cell sarcoma, and with excuse. Sections from *many* parts of any growth should be studied before a safe opinion can be ventured as to malignancy or non-malignancy.

DR. DEFOREST WILLARD: Much as I respect the valuable services of the pathologist, I am still inclined to rely more upon the results of clinical experience,

DR. BENJAMIN LEE: The case impresses me very clearly as one of malignant disease. The peculiarities of the tumor, the nodes alternating with small areas of fluctuation; the size of the fungus excresence seem to me very characteristic, and not what we should find in a tubercular abscess. I noticed no sinus at the point of incision and excrescence. The sinuses are old ones in connection with the tubercular disease of the joint. The excrescence came from a new growth, with a history of only a few weeks. I cannot conceive it possible to have this fungoid condition as a result of tubercular disease.

## PHILADELPHIA COUNTY MEDICAL SOCIETY.

*Meeting February 14, 1894.*

Drs. Keen and Mitchell presented a paper entitled

### REMOVAL OF THE GASSERIAN GANGLION AS THE LAST OF FOURTEEN OPERATIONS IN THIRTEEN YEARS FOR TIC DOULOUREAUX.

#### DISCUSSION

DR. JAMES HENDRIE LLOYD; I had the opportunity of witnessing this operation by Dr. Keen, which has been followed by such brilliant results. I wish simply to discuss briefly the pathological aspect of this case, and to refer to a case which I have had under observation within the last year, and in which the termination has been satisfactory although no operative treatment was employed. With reference to pathology, it has been customary to attribute this affection to a peripheral origin and to fight it back, step by step, until, as it were, we reach it in its central location. I think that that should teach us that probably the disease is not really of peripheral origin in all cases, but that in some of these cases it is essentially a disease of the ganglion itself, and that probably the reason that so many of these operations fail is because at first the operation is confined to one or two isolated nerve trunks. The sensory nervous system originates in the ganglion. It is not of medullary origin in any sense. Embryologists and histologists know that the central nervous system is divided into two zones or areas, the so-called zones of His. The medullary zone including the motor system springs entirely from the cells of the anterior horns, and the sensory zone springs entirely from the ganglia of the posterior nerve roots. These ganglia of the posterior nerve roots, especially in the embryo, are of great relative size and importance and of considerable complexity of structure. As late as yesterday I had the opportunity of studying sections of the cord of the embryo pig. In these I was struck with the great size and evident importance of the ganglia of the posterior nerve roots from which the whole sensory system springs. They are almost one-quarter as large as the cord itself. The importance which I attach to this, especially in cases of this kind, is that we can readily see the analogy that may exist in diseases of this sensory zone and diseases that exist in the motor zone. It is well known clinically that some of our more important, progressive, and chronic diseases of the motor system originate in the multipolar cells of the anterior cornua. These diseases, such, for instance, as progressive muscular atrophy, are slow and insidious and attack the nerve cells one by one, and with this there is corresponding deterioration of the nerve fibre and ultimately of the muscular fibre. We can readily see that in diseases like trifacial neuralgia we may have an analogous condition in the centres which are in the large ganglia of which the Gasserian is a type. I think that in some of these cases we have a slow, insidious process going on in these ganglia which is reflected outward through the affected nerve trunks. These nerve trunks are attacked by the surgeon, but the insidious process keeps on and is reflected out over more and more of the nerve trunks that are left. This

is pre-eminently the history of these operations on the fifth nerve. This fact suggests to my mind that in all probability this trouble, just as is progressive muscular atrophy, is a disease of the ganglionic nerve cells.

The fact that a neuritis is found by the microscope in the excised nerve trunk does not in any sense invalidate this theory. The neuritis may easily be a continuation outward of a central process.

If this view is correct surgeons are amply justified, since Rose, Keen, and others have shown the way, in attacking this obstinate affection in its head centre, which in this case is the Gasserian ganglion. There is nothing irrational, although there may be something theoretical in this view. I hope that in this particular case there will be a thorough microscopical study made of the condition of the Gasserian ganglion.

There are a few of these cases, which undoubtedly do well without surgical interference. It may be that the recovery is only temporary and that in time to come such cases will have a recurrence. I have had under observation for several years a lady who has had excruciating neuralgia of the inferior dental nerve at the point where it emerges from the mental foramen. The last attack continued for nine months. The pain was almost strictly isolated to the distribution of the nerve on the chin. In addition, however, there were occasional shooting pains through the lingual or gustatory nerve. This is an important point in connection with the pathology. It indicates that the affection was not peripheral. The lingual and inferior dental nerves are branches of the inferior maxillary branch of the fifth nerve. They emerge almost together from the Gasserian ganglion, but afterward have little mutual relation. The supposition, therefore, in such a case is that there was a central origin of the pain. In that case operation was considered, but not recommended. I was gratified to find that in this case expectant treatment, although long continued and including a trip to Florida, brought the suffering to a point where it could be borne with patience. Whether or not it will return and attack other nerve trunks remain to be seen.

DR. WHARTON SINKLER: When we come to consider the pathology trigeminal neuralgia, there is a great deal that might be said.

I am not prepared to accept fully Dr. Lloyd's view that the origin of the disease is to be found in the ganglion, for one sees many cases in which the neuralgia is to be traced directly to some peripheral irritation. It also seems scarcely probable that if the disease were always central excision of the nerve would be followed by relief lasting for several years, as is often the case.

The tendency toward surgical interference in neuralgia of the fifth nerve has increased very much of late years, Dr. J. J. Putnam expressed the opinion in a recent paper, that it is not worth while to attempt medicinal measures in these cases, but urges the excision of the nerve as far back as possible be at once resorted to. Dr. Keen goes further and makes the suggestion that it may be desirable to begin at once with the removal of the ganglion. It seems to me that these measures are too radical. We know that in excision the ultimate results are far from satisfactory, and like the relief from nerve-stretching, it is of brief duration. In the case of the operation for removal of the Gasserian ganglion, we do not know how permanent the relief may be. In all of the five cases operated on by Rose there was relief up to the time that the cases were reported, but the longest time after operation in any case was only twenty-two months, and in one of the cases the operation had been done only sixteen days. Then we must consider the mortality which follows the operation. According to the statistics given by Dr. Keen, forty cases have been operated on with six deaths, a death rate of fifteen per cent., which is a rather formidable mortality in a disease which does not threaten life. It therefore seems to me that before resorting to operative procedures we should use other remedies. There are certainly many cases that are relieved by medicinal means—that is, by the administration of drugs and the use of galvanism. I have now under my care an old lady over eighty years of age, who for the past five or six years has suffered from the most violent attacks of tic douloureux, and who is most invariably relieved by gelsemium pushed to physiological doses. Of course, when drugs fail, we must be thankful for having the opportunity to resort to an operation which has given such complete relief as excision of the Gasserian ganglion. I notice by the way, that Horsely questions very much whether the entire ganglion has ever been removed. He doubts if this be possible.

DR. FRANCIS X. DERCUM. I have little to add to what has already been said. I think that in these cases we should be guided rather by what we know of the pathology. While Dr. Lloyd's speculations are interesting, I hardly think that we can allow them to guide us in the choice of so radical an operation which is not without some danger.

It is certain that in some of these cases, at least, there is inflammation present in the nerve trunk itself. I know of at least four cases in which the microscope shows actual lesion in the nerve trunk to account for the pain. In one case where the infra-orbital and the inferior maxillary nerves were re-

moved, complete relief was afforded until the death of the patient some years later.

With regard to medicinal measures, I think that a definite plan should be pursued. We should in these cases search for diathetic troubles. In some cases we find the rheumatic diathesis, and even if it is not present, a short course of the salicylates will do no harm. I have seen the salicylates in full doses give great relief, so great that the patient would be without pain for months. It has occured to me that we might also make use of piperazin, which in chronic form of nerve trouble is often of extreme value. In fact, some of the principles that guide us in the use of drugs in the treatment of sciatica should guide us in the treatment of this trouble, which is far oftener a neuritis than we are apt to think.

With regard to the possibility of excising the entire ganglion. It seems to me that it is possible to destroy the great bulk of the ganglion—at least, the posterior two-thirds. Whether or not the part supplying the ophthalmic region was touched in this case, I cannot say,

DR. JOHN B. ROBERTS; I am interested in the fact that the mass of gauze did not produce any great amount of disturbance. This only enforces what I have had long on my mind, that what we usually call compression of the brain is probably nearly always inflammation. We can have a good deal inside of the skull, such as bone or clot, with a very few symptoms, if sepsis be excluded. I do not believe much in compression of the brain after fracture, but think that the symptoms are nearly always due to inflammation the result of the irritation and probably a septic irritation of the brain tissues, That may not be neurologically correct, but it has stood me in good stead surgically as a clinical experience.

The elaborate engine shown, seems to work very satisfactorily. For my work, however, I would rather use a sharp chisel and a mallet with my hands, than any mechanical device.

These are apt to get out of order and must be kept in a place such as a hospital where they can be readily put in repair. What we want to do is to train our hands to do the work and not be dependent upon any mechanical device. The patient whom I shall show was operated on for intra-cranial neurectomy with great satisfaction with a small chisel, not the ordinary chisel for operating on the large bones, but such as we would use for delicate work, and one having the shape of a small osteotome. The chisel should be very sharp and the corner of it should be used for cutting the groove in the bone. I am getting into the habit of using the chisel rather than the trephine and am coming to think that the trephine is a little oldfashioned.

This is the man whose case I reported a year ago, and showed the second and third divisions of the fifth nerve, which I had excised in front of the Gasserian ganglion for tic douloureux. The man had had neuralgia for many years and had been operated on peripherally many times with relief for six or ten months, or even a year or two. I ligated the carotid artery, giving relief for a year; but the pain returned, and a year ago last December I did the intra-cranial operation, making the osteoplastic resection of Hartley, removed the second and third divisions of the nerve back to the Gasserian ganglion, but did not get out the ganglion. He has been absolutely comfortable for the last fourteen months. This man had no inflammation of the eye following the operation. I stitched the lids together before opening the skull. The nerves removed have been submitted to a pathologist, but so far I have had no report.

Here is another man on whom I have done a different operation for the same affection. He had intense neuralgia of the infra-orbital. I excised the nerve and he had comfort for two years. Two and a half months ago he came back saying that the pain had returned. Not thinking it proper to at once go into the interior of the cranium, I resected the ganglion of Meckel. I made an inverted V-shaped incision over the zygoma, familiar to all surgeons, sawed the zygoma in two places, turned down the musculo-osseous flap, and sought for the ganglion in the pterygo-maxillary fossa. I did not recognize the ganglion, but tore out what was in its vicinity. The internal maxillary artery was divided in the operation. The patient has comfort now, but it is only two months since the operation.

In another case ligation of the carotid afforded relief for a number of months, but then the pain returned. It seems to me, therefore, that the proper method is to begin peripherally excising the painfnl nerves and to repeat the operation as the pain returns until we finally get back to the ganglion of Gasser.

DR. BRUCE BURNS: I certainly believe that Dr. Lloyd is right, that in a certain number of these cases the affection is due to changes in the ganglion. In selecting the treatment of these cases a great deal of differentiation is required. There may be some cases arising from the periphery as the result of neuritis, neuroma, exotosis, etc. I have had some experience in operating on these cases. While the immediate results have been satisfactory, the results as regards ultimate recovery have not been good. One case was that of a lady sixty-five years of age, who had suffered from severe neuralgia for over thirty years, most of the time being con-

fined to bed. She had become an opium-eater and relied on large doses of whiskey or brandy for temporary relief. The teeth had long ago been extracted. After watching the case and knowing that medical measures had been given a thorough trial, I advised operation. In that case I trephined the superior maxillary and removed an inch and a half of the infra-orbital nerve; I also resected the inferior dental nerve in its whole length. Relief followed and continued for about two years. The pain returned and the general condition was so bad that I hardly thought it advisable to recommend further operation. The patient insisted that something be done, and I finally determined to attempt the removal of the superior maxillary bone. Before the operation was concluded the shock became so extreme that I desisted and the patient died shortly afterward.

Within the last twelve months I have had another case which I think is of ganglionic origin. There I removed the infra-orbital and the inferior dental. This gave a great deal of relief until a few weeks ago, when after exposure to cold there was a return of the trouble.

As I said before, I believe that in our treatment we should differentiate between the cases that are of peripheral and those that are of ganglionic origin.

DR. EDWARD JACKSON: In describing the operation, reference was made to the obstacle of bleeding at two separate stages; one due to rupture of a branch of the anterior meningeal artery was promptly controlled, and the other occurred on raising the brain, was not clearly accounted for, and caused the suspension of the operation. In conversation, Dr. E. W. Stevens has mentioned to me a point in anatomy that throws light upon this. In the dissecting-room his attention has this winter been directed toward this operation, and he has almost constantly found two veins of considerable size entering the bone at this point, so that they would necessarily be torn in the separation of the brain from the floor of the skull in order to get sufficient room to reach the ganglion.

THE PRESIDENT, DR. WILLARD: Having had occasion in the last few months to look up this subject, and as the operation of Rose has not been described to night, it may be of interest to show diagrams illustrating Rose's operation. This operator cuts through the zygoma, saws off and turns back the coronoid process, and ligates the internal maxillary artery. He then reaches the foramen ovale and applies a trephine directly beside the nerve and then through this opening removes the ganglion with a curved hook. This route will probably be selected by surgeons unaccustomed to intra-cranial work.

Rose reports 7 cases with only 1 death from meningitis, and Andrews 4 with 1 death. In a collection of 40 cases which I have made, there were 6 deaths. These cases represent results obtained both by the Rose and by the Hartley or Krause method.

With regard to the removal of the entire ganglion, it has been almost the universal experience of operators, either through the spheno-maxillary fossa or within the cranium, that while they have believed that they have excised the ganglion, they have not been at all certain that the entire mass was removed.

DR. KEEN: I regret that I was prevented from arriving till so late that I am not able to take part in the discussion. I wish, however, to show the electric lamp to which reference has been made. The lamp is that made by Hirschman, of Berlin. The storage battery is made by Mr. Fleming, of this city. The battery has ten cells and is provided with two rheostats, so that with one I can use the electric light or galvanic current. The other can be used for galvano-caustic purposes. In the lid is a large compartment in which the lamp, etc., may be carried.

DR. MITCHELL: As to the origin of this affection, it seems probable that in many of these cases the origin is not central. This point was discussed in the paper. While such an origin is possible, I do not believe that it is always or commonly the case. If the disease originated in the ganglion, operations on the peripheral nerves would not give the relief that we find to follow in many of these cases.

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**Ruined his Prospects.**

Dismal Dawson. "They's is one feller, if I ever meet him, I mean to beat the face off him."

Hungry Higgins, "Who is he?"

Dismal Dawson. "The doctor that doctored in our family when I was a kid. Ef it hadn't of been for his fool interferin' I might be takin' in plenty of money every day on them fits right now."—*Indianapolis Journal.*

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ALLOPATHIC CURE. — If your piano does not work well, open the top and pour in a pail of strong soap suds and brine. Homœpathic Cure.—If your piano does not work well drop a grain of sugar in one of the hollow mahogany legs.—*Minneapolis Journal.*

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All people have their trials, except perhaps, the rich rascals who can suppress the indictments against them.

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*Antiseptic Therapeutics*, E. Trouessart, translated by E. P. Hurd, 2 vols., constituting part of the Physicians' Leisure Hour Library, published by Geo. S. Davis, Detroit; 25 cents for single numbers; $2.50 per annum.

The first volume discusses the antiseptic and toxic powers of inorganic and organic chemicals; the second volume is classified by diseases, ending with an abridgement of the author's third part on antiseptics in hygiene and nursing. Antiseptics are made to include not only substances ordinarily so considered, but remedies which neutralize toxines, whether produced by a bacterium, a fungus, or even by perverted cells of the body, as in rheumatism and gout. Some excellent generalizations are made as to the relation between antiseptic power and chemical constitution. We are told that "The group naphtyl, $C_{10}H_7$, is about twice as antiseptic as the group phenyl, $C_6H_5$, and the latter is five or six times more energetic than the group methyl, $CH_3$."

We are pleased to note that the metric system is used, with few exceptions. A number of inaccuracies detract from the value of the work for ready reference, although they are mainly self-correcting if the books are carefully read. The work is a little disappointing, not from any fault of the author or translator, but on account of the present lack of precise information. Its special value is to present facts already known in a new light and to stimulate further experimentation with internal antiseptics.

*How to Use the Forceps*, with an introductory account of the Female Pelvis and of the Mechanism of Delivery, by Henry G. Landis. A.M., M.D., Professor of Obstetrics and Diseases of Women and Children in Starling Medical College, Columbus, O. Revised and enlarged by Charles H. Bushong, M.D., Assistant Gynæcologist and Pathologist to Demilt Dispensary, New York. Illustrated. New York: E. B. Treat, publisher, 5 Cooper Union. 1894. pp. 203. Price, $1.75.

This book contains a very clear and concise account of the pelvic canal, from the standpoint of the obstetrician, as well as the method in which the fetal head passes through it. The criticism to be made is rather on what has been left out than what has been said.

For instance, concerning the question, Why does internal rotation occur especially in posterior positions?, the author makes no mention of the pelvic soft parts, but assigns the cause to inclined planes of the bony canal, torsion of the neck, etc. Now it is generally admitted that the chief factor in internal rotation is the resistance of the soft parts to the most advanced part of the fetal head, and the most important component of the soft parts is the levator ani muscle. Much importance is given to *the perineal body* as a force in labor, and the author states that "the muscles attached to *the fibrous perineal body* should be considered as a part of it when describing it." However, the following sentence will disclose the lack of his appreciation of the function of the levator ani muscle: "As the head escapes from the vulvar orifice the perineal tissues retract to nearly their original condition, chiefly by *reason of their inherent elasticity, aided somewhat by the action of the transverse muscles of the perineum.*"

Concerning the kind of forceps to be used the author expresses his preference for the Davis forceps. He finds this, *properly used*, all sufficient for traction in the axis of the birth canal. He alludes to the Tarnier forceps as "an unnecessarily ingenious contrivance." The fact that the latter admit of natural internal rotation and flexion and extension while traction is being made, does not seem to have outweighed the other in usefulness in his estimation. As to anæsthetics when using the forceps, the author says, "the use of anæsthetics is neither necessary nor advisable."

The book is a very instructive one, and will amply repay careful study on the part of any one who is interested in this branch of medicine.

*Lehrbuch der Fracturen und Luxationen, fuer Aerzte und Studierende.* Bearbeiet von Dr. Albert Hoffa, Privat-docent der Chirurgie an der Universitaet Wuerzburg. Second augmented and improved edition, with 395 illustrations in the text and 29 colored plates. 705 pp. Stahel'sche Hof-und Universitaets-Buchhund Kunst-Handlung. Wuerzburg.

This eminently practical work on fractures and luxations is written by one who is well known in surgery, and especially in orthopœdic work. It is intended to present a clear and practical exposition of the subject to both student and practitioner, and to present this subject in the present condition of surgery. Therefore has attention not only been paid to pathological anatomy, but also to differential diagnosis and therapeutics of the various conditions, so that with simple means one may obtain good results. Of the various means of bandaging and dressing only those have been included which have stood the test of time and experience. In order that one may have a clear idea of the subject there are incorporated, in the text, numerous illustrations, with a series of colored plates, at the end. In the explanations he has sought to present all the relations which might assist dislocation of the fragments and to bring forward types which, once seen, the deviations may be easily noticed. The consideration of each subject is full and quite complete, and well up with the advances in this branch of medicine. The second edition has undergone many improvements and much elaboration. Above all, the writer has sought to include recent advances with regard to both the German and foreign literature. The new methods of treatment have been tried on the material under his care, as much as possible, and that incorporated which has been found practical. The rarer fractures and luxations are rendered

clearer and more easily comprehended by including histories of cases and pathologico-anatomically well analyzed cases, in the text, together with a number of new figures. It has met with a favorable reception in Germany.

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*The Year-Book of Treatment for* 1894, A comprehensive and Critical Review for Practitioners of Medicine and Surgery. In a series of twenty-four chapters, by eminent specialists. In one 12mo. volume of 497 pages. Cloth, $1.50. Philadelphia, Lea Brothers & Co., 1894.

In the ten years of its publication, The Year-Book of Treatment has firmly established itself as an invaluable aid for all those who desire to keep posted on the current additions to the world's knowledge of the management of disease. The word "treatment" is construed in its broadest sense, including medicine, surgery, gynecology, obstetrics, pædiatrics, and all the specialties, in a series of twenty-four chapters, each contributed by a gentleman eminent in his assigned subject. Bacteriology and hygiene are compendiously dealt with, and the Summary of Therapeutics for the year presents this most important subject in the most available form for use. The various articles are sufficiently detailed for all practical purposes, but references to original papers are given for the convenience of those desiring to make extended research.

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# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

## ARCHIVES OF PEDIATRICS.

In the March number, Dr. A. Brothers continues an article on the

**Treatment of Empyema in Early Life,**

giving an historical review of the methods that have been resorted to.

Operations he classifies under the heads of puncture and methods by the knife.

This article covers the subject very completely, giving as concisely as possible the differences in the operations practiced by different men, and finally the author concludes with his own experience, and his reasons for preferring incision to puncture with the aspirator.

Puncture with the aspirator the author thinks useful to temporarily relieve a case, until the system can be built up and incision made.

In children, section of ribs is rarely called for, unless the case is one of long standing. In adults, however, the case is different, and it is usually necessary to divide one or more ribs to insure the closure of the cavity. As soon as pus is diagnosed, the author declares the only treatment to be prompt and free incision with drainage.

Dr. George Carpenter writes of the

**Incubation Period of Scarlatina, etc.**

Most authors, he states, declare the incubation to be from two to eight days, but the writer quotes cases which seem to show that it may range from two days to three weeks. This should lead to a longer period of quarantine of those convalescing from this disease than is at present demanded by law. The author emphasizes the fact that so long as desquamation is taking place, whether in the scalp or elsewhere, the patient is capable of acting as an infecting centre to others.

whiskey, in diphtheria. The drug has sev-

Dr. Talbot R. Chambers gives his experience with tincture of nux, as a substitute for eral advantages and was used in dose sufficient to sustain the pulse, etc., in about its normal condition.

In the first case mentioned the required dose was one minim every half hour at first, and less frequently later on.

Dr. D. J. Milton Miller writes of the value of alkalies and aromatics in digestive disorders of children.

In the condition known as mucous disease, due to improper feeding, the author states that combination of these two classes of drugs acts by the solvent and antacid power of the alkalies, and the power aromatics have of dissipating pain and spasm. Alkalies also, when diluted and given on an empty stomach, appear to stimulate the secretion of gastric juice. The author describes some typical cases and his treatment of them. Besides restricting the amount of farinaceous food, he administered soda bicarb., sp. ammonii aromat., glycerin and aqua mentha, with or without sp. chloroform, and tr. capsicum.

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## JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

Dr. John T. Bowen, reports a case of

**Hydroa Vacciniformis**

the first, he believes reported in America. The patient was a white boy, and without important family history. Since five years of age, the boy has had after exposures to the sun, repeated attacks of this trouble, more frequent in Summer. He has never been free for more than two months at a time, even in the winter season.

Of late a few lesion appeared on the hands, also, but usually the face alone was affected. Sometimes an attack was ushered in with malaise and vomiting; sometimes not.

The patient is undersized and anæmic, with face, especially the nose and malar prominences, covered with cicatrices precisely resembling those of variola: these cease gradually at the hairline of the scalp.

The eruption consists first of red papules, which become vesicular and vesico-pustular. These may now enlarge, and sometimes present a marked umbilication surrounded by a clear or turbid fluid, which in turn is circled by an erythematous halo.

Only the most advanced lesions are umbilicated, and the centre of these presents a peculiar dark blue or black aspect, which is due not to the contents but to the floor of the lesion, and in many cases, the author states, this dark floor presents points of still darker color. The lesions may become confluent.

During the next stage the dark centre and its covering are replaced by a very adherent thick black crust, which is finally cast off, leaving a deep punched-out pit, usually circular, and at first deep red in color.

The author states there was no pigmentation, but in some places new lesions were forming in old pits. Few sores appeared on the hands, none above the wrisks, and none on any other parts of the body.

The cervical, submaxillary, and inguinal glands were enlarged but all others appeared normal.

Under the use of a carbolized zinc oxide lotion, and the internal use of iron, the case improved more rapidly than usual, but had a second attack after a short respite. Another and more severe attack came on after going out on a sunny, but very cold December day, and this time the face was much swollen at first. Itching rarely occurs in these cases, although it was a prominent symptom in this one, and the attacks grow milder as the patient grows older, until they disappear in adults.

Microscopic examination of a typical lesion shows necrosis of both epidermis and corium, reaching almost to the subcutaneous tissue, but ceasing very abruptly at both the side and bottom. Near the lesion the epidermis is thickened and the corium full of small round cells. Hair follicles and sweat glands are numerous and normal. Examination for micro-organisms gave no results of importance. Examination of a less fully developed papule showed that the trouble begins in the epidermis and upper part of the corium, and if at this point improvement does not set in the part involved and the corium immediately underneath become necrotic.

The necrotic process differs from that of variola in being secondary to the vesiculation, while in variola Weigert found necrosis to be primary.

As in all other skin diseases where umbilication appears, it seems due to the central necrotic area holding down the centre of the lesion, while the epidermis around is allowed to proliferate and form a raised border.

The treatment has not been very successful, the author says, but veils of red or turmeric colors, by neutralizing the chemical rays of the sun, would go far toward preventing the disorder.

Dr. Heumann G. Klotz writes on

**Antisepsis in the Treatment of Eczema.**

This principle, he says, now so carefully observed in general surgery, is neglected greatly in dermatology, where the conditions are generally such as to invite sepsis constantly.

The reason for this neglect, the author thinks, is due to the fact that the drug in most general use to prevent sepsis elsewhere, carbolic acid, is injurious to the skin and often seems, unless used with extreme care, to render any irritation of the skin worse. The author prefers to use weak solutions of bichloride of mercury, 1:3000 to 1:5000, preferring solutions in almost all cases to ointments, contrary to the usual teaching of dermatologists. He also has success with boric acid, sometimes uses it in ten per cent. ointment after applying a bichloride lotion for a time. The author goes on to show that almost every one of the so-called soothing lotions in popular use for a long time are of more or less antiseptic value, (even infusion of chamomile) and the ideal preparation is one which, while not strong enough to be irritating, is yet antiseptic and which will favor new skin production. The author then mentions ichthyol in 1 to 1,000 or 2 to 1,000 strength, salicylic acid, thymol, resorcin, etc., but seems to prefer a mixture of fifteen or twenty grammes of boric acid, two to five grammes acetate of lead, a half pint of lime water with enough boiled water to make a quart; sometimes adding to this a small amount of glycerine and alcohol.

Dusting powders are useful and are preferably made of boric acid, etc., with some mineral powder such as talcum, magnesia carbonate, or kaolin, rather than vegetable preparations, such as starch. Some of the plasters in common use, the author thinks ideal antiseptics, requiring only the addition of cotton or some absorbent to make them perfect.

Dr. J. H. Pooley describes a case of

**Molluscum Fibrosum,**

the subject being a man, now fifty-eight years old, who when a boy of ten years had an attack of so-called erysipelas. During convalescence the skin peeled off from face and body, and shortly afterward a number of small elevations appeared over the body. These are scattered over the head, neck and limbs, the author says, but over the back and chest are as thickly placed as possible. Microscopically they prove to be molluscum fibrosum and the only noteworthy features are their uniform size, and their apparent connection with the erysipelas. No known family history throws any light on the case.

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THE EDINBURGH MEDICAL JOURNAL

for March contains a paper by W. G. Aitchison Robertson, M. D., on

**The Fermentation of Sugars.**

As the result of the author's investigations he presents the following practical deductions:

In cases of dyspepsia there is usually much delay in the absorption of carbohydrates, even when digested. They are consequently exceedingly prone to undergo fermentation, and this is specially apt to occur if the carbohydrate be in slight excess.

In that variety of dyspepsia accompanied by lactic fermentation, the use of those sugars which rapidly undergo the lactic change, viz., dextrose, lævulose, and invert sugar, is contra-indicated, while the moderate use of cane sugar, maltose, and lactose may be allowed.

In those cases of dyspepsia where butyric fermentasion is prominent, milk sugar would seem to be the most suitable, as it is least easily changed by ferment. On the other hand, maltose is very readily changed, as the other sugars also are to a lesser degree.

Lastly, in dyspepsia associated with the alcoholic and acetic acid fermentations, cane sugar, dextrose, maltose, and lactose may be allowed in small amounts; while invert sugar and lævulose should be forbidden. Lactose, however, is the sugar to give in this condition, as it is not at all acted on by the alcoholic ferment.

These theoretical deductions have been supported by clinical observation in the case of cane and invert sugar. The author leaves it for future investigation to show whether they are true as regards the other sugars.

F. W. N. Haultain, M. D., contributes a paper on

**Dilatation of the Cervix by Champetier De Ribes's Bag.**

The instrument simply consists in a silk bag covered by india-rubber, which, when distended, assumes the definite shape of an inverted cone, measuring at its base about 3½ inches in diameter.

For the purpose of introducing the dilator, a pair of separable forceps have been devised, which are of great value when the initial dilatation is not greater than the diameter of a quarter dollar; but when larger than this, the introduction of the bag can be most conveniently performed by means of a pair of ordinary curved vaginal forceps.

The not inconsiderable dimensions of the collapsed bag make it necessary that a certain amount of initial dilatation requires to be present before introduction can be attempted, the amount necessary being slightly larger than the diameter of a quarter dollar; or, in other words, the os requires to admit one finger fairly easily.

Before introduction the bag should be crumpled into as small a compass as possible and thoroughly oiled. It is then grasped by the application forceps and slowly pushed through the cervix till at least a half has passed the os internum.

The forceps are now loosened, and partial distention (by means of warm water pumped in by an ordinary Higginson syringe) commenced; the forceps are now withdrawn and full distention completed, this being estimated by a known number of syringefuls being necessary.

As the bag distends it becomes accommodated to the surrounding parts and adapted to the existing degree of cervical dilatation existing, its curved shape allowing it easily to lie on the axis of the pelvic brim.

From the large size of the bag, the pressure on the presenting part must necessarily be considerable, and thus tend to displacement, —a disadvantage in its use.

The bag in its shape corresponds with the normal bag of waters for which it forms a most excellent substitute, as the author has on more than one occasion proved. But as a simple substitute for the normal membranes its benefits as a dilator are by no means exhausted, because when rapid and more forcible dilatation is required it is of great service in forming a most efficient point of resistance to the finger in performing digital dilatation. Further, by making traction on the bag considerable assistance can be given to feeble uterine contractions, and even dilatation attained where they are entirely absent.

Although the main function of the instrument is as a dilator, it must undoubtedly act benefically in cases where the membranes have been long ruptured, by preventing compression of the soft parts between the presenting head and the pelvis, through forming a basis upon which the fœtal head rests. This action upon the presenting part where exaggerated, although forming one of the stated objections to the use of the bag, must be looked upon in some cases as of distinct value, as where compression of the cord is thus avoided.

The author believes that the instrument is of especial advantage in the induction of premature labor in which operation it has been extensively used in France.

As regards any special danger in using the dilator, the only one which suggests itself to his mind is the introduction of the bag in cases where after prolonged labor the lower uterine segment has become much thinned; here its introduction may be the means of causing rupture of the uterus, otherwise its employment under ordinary antiseptic precautions seems at all times safe.

Appended to the paper is the report of several cases in which the author made use of the bag.

W. Ramsay Smith M. B. describes a

**Definite Form of Skin Disease Allied to Erythema and Urticaria.**

The first time he saw the rash was on an infant six months old. The eruption, which partook of the nature of an erythema or an urticaria, was distributed pretty much all over the body, but was specially abundant in a zone round the upper part of the abdomen.

The spots were single, as a rule, although here and there some were so close as to appear confluent. The appearance of the spots raised a strong suspicion that they might be due to the bites of insects. The boy had been in the garden playing among grass, and several of the spots had a central mark closely resembling the injury inflicted by a sting or a

sharp pair of jaws. Subsequent observation convinced him that this theory was untenable. Some of the spots had no such mark, but were really wheals. The majority, however, consisted of white or very pale pink spots, varying in diameter from an eighth to half an inch, becoming red within an hour or two, and then fading away in four or five days,—other crops appearing in the meantime, and running a similar course. Some of the "spots" became hard and shotty in the skin; some, especially on the dorsal aspect of the fingers and toes, became almost warty, and remained for a week or more; and others became vesicular, and burst, exuding a clear coagulable fluid. The skin, in these cases, would take two or three weeks to assume its normal appearance. Intense itchiness of the skin, and a considerable amount of constitutional disturbance, were associated with the appearance of the rash. The attack passed off, but recurred after a few weeks, when the same train of symptoms was repeated.

The author describes five other cases of the same disease. He relies chiefly upon constitutional treatment. In children most benefit seems to arise from a smart purge of calomel. He has tried quinine in large doses at the beginning of an attack, and also antipyrine, both with some degree of temporary advantage, but he puts the most trust in the efficacy of calomel. In adults the disease is often very troublesome, and sometimes the treatment is very prolonged and the improvement very slow indeed.

This issue of the journal also contains the second of the Morrison Lectures on Insanity by John Batty Tuke, M. D. John Wylie, M. D., continues a paper on "The Disorders of Speech;" this number being devoted to the consideration of aphasia and other disturbances of speech in relation to evanescent organic affections and functional disorders of the cerebral cortex. James Ritchie, M. D., discusses "Prolapse of the Bladder during Pregnancy and Parturition," reporting a case.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## THERAPEUTICS.

### Atropine in Morphinism.

Prof. W. Kochs, of Bonn (*Therap. Montash*).

Last year the author had occasion to treat a case of severe morphinism, in which considerable quantities of the drug had been taken, and very alarming symptoms were produced. It was necessary to directly counteract the poison; five times during ten months Prof. Kochs used, in this case, atropine with the very best results. The patient was dismissed, but returned repeatedly, falling a victim to the habit. The author states that, to his knowledge, atropine had not, until then been used in morphinism, and considers that the symptomatic antagonism of these two drugs has not been sufficiently appreciated. Many do not accept the view that atrophine is capable of contracting the action of morphine.

It is well to begin with very small doses of atropine subcutaneously (0.0002 gme. [1-333 gr.]). and double the dose if necessary.

### Some Points in the Treatment of the Uric-Acid Diathesis.

F. E. Stewart, M. D., Ph. D. (*Therap Gaz.*).

The author's main idea in the above paper is to prove the great efficacy of warm saline baths, as given at certain springs in Germany and in the United States, in the treatment of the uric-acid diathesis. He recommends that in conjunction with the baths there should be administered potassium bicarbonate, in doses of forty grains, to render the urine alkaline; and that a diet be maintained of animal food: milk, 1 to 1½ pints, eggs, fish, fowl, or game, 1 to 4 ounces varied a little from day to day. Of vegetable food, vegetable prepared products, vegetables twice a day; fruit three times a day, to any desired extent, according to appetite. Tea, coffee, cocoa in moderation, and as flavorings rather than as strong decoctions. He also recommends exercise in the open air, preferably under conditions where the mind as well as the body will receive excitation; and indoors by light gymnastic practice, fencing, Swedish movements, and massage. He claims that in many cases the uric-acid diathesis can be successfully treated by the use of the natural saline baths (93°F.) by diet and exercise, without the administration of drugs; and in cases where drugs are necessary, their salutary effects are increased by the baths, etc.

### Absorbing Power of the Bladder.

Physiology has hitherto taught that the bladder is one of the organs which are covered with epithelium and which possess no absorbing power. The author states that clinical observation led him to suppose that the healthy bladder must certainly possess some absorptive power. His experiments consisted in the injection of certain chemical and microbic poisons within the bladder by means of a catheter. Only a slight amount must be injected, so as to avoid the effects of pressure and not cause the animal to urinate at once. Cocoine, strychnine, and medicinal hydrocyanic acid killed the animals within a few minutes. Water appears to be absorbed to some extent by the bladder, but no absolute proof of this can yet be given. The absorption of chemical poisons by the bladder may throw some light upon urinary pathology and give an explanation of the fact that,

from the evolutionary standpoint, renel retentions allows of longer preservation of life and health than retention within the bladder.

Pneumococci, septic vibrios, and the pyretogenic substance of Charrin, when injected in the bladder, all caused death in the majority of instances, after variable lapses of time. Death occurred in five out of six rabbits after pneumococcus injections, and pleural and peritoneal exudations were found to have taken place while there were no renal lesions.

## MEDICINE.

### Elliot (G.) on Appendicitis from the Point of View of the Physician.

From an etiological, as well as from a pathological point of view, the patient with appendicitis has many chances of his disease terminating fatally. Before pus has formed, before ulceration has perforated the coats of the appendix, and before the appendix has become gangrenous and sloughed, the danger to the patient is a prospective one. During this stage of the malady, the physician must adopt a course of active medical treatment. Morphine should be administered in large doses subcutaneously, and should be repeated at short intervals until the pain is entirely relieved. A mustard plaster should be applied until the skin is reddened, and this should be followed by hot flaxseed poultices. A saline cathartic—sulphate of magnesia, in drachm doses, is the best—should be repeated every hour or two, until copious watery movements from the bowels occur. These measures tend to relieve the congestion of the intestinal mucous membrane, and to modify the inflammatory action. If the case is one of so-called catarrhal appendicitis, in which there is no foreign body and no abnormal concretion giving rise to the inflammatory process, the inflammation may undergo speedy resolution and the patient quickly becomes convalescent. But, on the other hand, resolution may not ensue, and the patient may not get well.

If, however, the trouble is caused by a foreign body, or an intestinal concretion, these measures will do little good, except to keep the patient quiet, while the doctor is thinking what to do next.

Cases of this kind, and cases of catarrhal appendicitis, which have not undergone resolution, may be classed together. They are of great gravity and importance. Unfortunately, during the first stage of the disease it is generally impossible to tell just what the cause of the trouble is.

How long may medical treatment be continued? For not more than twenty-four hours, and not later than forty-eight hours, from the commencement of the disease, unless distinct evidence of positive and continuous improvement is observed. If it is not observed, call upon a surgeon to operate, and call upon one who will operate. In this way alone will you do your duty by your patient.—*Boston Med. and Surg. Jour.*

### Rheumatic Skin Eruptions.

Dr. Travers Smith, of Dublin, quoting from Drs. Barlow and Cheadle, says that skin eruptions may be the only manifestation, present at one time, of rheumatism. The rashes, when widely diffused over the body, closely simulate those of measles, German measles, and scarlatina. The difficulty of differentiating is further enhanced by tonsillitis, which may owe its origin to a rheumatic factor. Attention to the following points generally enables one to form a correct diagnosis: (1.) The mode of distribution of the eruption, which manifests itself first on the extremities and may be entirely limited to them. (2.) The *tout ensemble* of the constitutional symptoms, *e. g.*, there being no distinct and sudden invasion or catarrh as in measles. (3.) The time of year. Most cases occur during the cold months and autumn. (4.) The possible concurrent prevalence of an epidemic of an exanthem should be ascertained. The evanescence of the rash and absence of subsequent pigmentation will exclude the syphilides. He quotes as follows from Dr. Cheadle's articles in Keating's *Cyclopædia:* "Always in the case of children, whether unmistakable arthritis be present, or there be merely a stiff and painful tendon, or an unexplained febrile attack, or chorea, or tonsillitis, or erythema, it is most essential to bear in mind the possibility of having to deal with rheumatism, and to examine the heart carefully day by day."— *The Dublin Journ. of Med. Science.*

### Olive Oil in Lead Colic.

M. de Prada records three observations, in which Weill and Combemale employed olive oil in doses of two hundred grammes as a deobstruent and sedative. These therapeutical effects have not been obtained by M. de Prada. The oil in this large dose is with difficulty assimilated by the patients, there being great gastric intolerance. He considers calomel to be superior to the oil; and that it is better to resort to salines, such as the salts of magnesium and sodium, or to calomel combined with sedatives, such as opium and phenazone.—*Lyon Medical.*

### Treatment of Infantile Eczema.

Harrison calls attention to the importance of regulation of the diet, and administration of alterations to the mother in the case of nursing infants. He has found small doses of arsenic (especially minute when the eczema is of highly inflammatory type) to have the best effect. In the way of local applications he prefers unguents to lotions and thinks there is nothing in the argument of non-cleanliness, for oils are really more detersive than water.—*Amer Jour of Obst.*

### Antipyretic Pills in Phthisis.

℞ Pulveris digitalis .....gr. j.
Quininae hydrochloratis.....gr. iss.
Pulveris opii .....gr. ss.
Misce et fiat pilula.
One to be given every six hours.

### Arsenic and Cancer.

Among the ingenious and plausible suggestions emanating from Mr. John Hutchinson, is the possibility of the evolution of epithelioma, being facilitated by a long course of arsenic. In his well-known paper on the subject he alleged a number of instances in which there was certainly presumptive evidence of arsenic having thus favored the evolution of the cancerous outbreak. At a recent meeting of the Clinical society, apropos of a case of multiple epithelioma following a course of arsenic, he called attention to certain peculiar changes in the skin of the palms and soles, which in his opinion indicate that it is time to desist from the administration of the drug, viz., a furfuraceous thickening of the skin in those situations. We call attention to this statement in order that our readers may avail themselves of any and every opportunity of ascertaining how far the suggestion is confirmed by clinical observation.—*Med. Press Notes.*

### Notes on the Physiological Action of Ozone Preparations.

Dr. W. G. Thompson draws the following conclusions respecting the effect of ozonizing agents when given by the stomach or injected directly into the intestines or the blood. The experiments were made on dogs.

1. When injected in the circulation in full strength, i. e., fifteen volumes per cent., they have a very destructive action upon the blood, ultimately having the effect of reducing rather than of oxydizing agents for the tissues.

2. Acting through the stomach or intestines, they may similarly affect the blood, and in addition they destroy the gastric and intestinal mucous membrane.

3. Given in medical doses by the stomach, their only benefit, if any, consists purely in their local action in the alimentary canal, in possibly preventing abnormal fermentations.

4. If so used, care should be exercised owing to the great variability in strength of different preparations.

5. Ozone is of no real value to the tissues, whether inhaled or drunk in fluid preparations, and it may be exceedingly harmful.—*Med. Rec.*

### A New Treatment for Tuberculosis of the Joint and Skin.

The old dictum that "all cyanosis was incompatible with tuberculosis," although originally applied to the lungs led to the suggestion that it might be equally useful in joint and skin affections of the same character. The technique of the method is simple. It consists in placing a broad elastic band around the affected limb a few inches above the diseased part, firm enough to produce venous congestion. The point of application should be changed from day to day to prevent abrasion. The distal portion of the limb is supported by a common roller up to the affected part so that the congested area is limited to the immediate neighborhood of the disease. Dr. Bier of Kiel who originated the treament reports upward of twenty cases in which the improvement attained was very rapid and striking. Miller reports in *Edinburg Medical and Surgical Journal* cautiously this treatment. His plan differs from Biers, in that the bandage is only applied for ten or twelve hours on alternate days. He recommends its use in:

1. Tubercular skin affections of the extremities.

2. Early tubercular disease of joints, (combined with immobilization or blisters,) especially those in which time is of no great importance.

3. Instances of multiple tubercular disease in which more radical treatment is inappropriate.—*Med. Rec.*

### Dangers of Piercing the Ears.

Thorner calls attention to the pathological conditions following the piercing of the lobules of the ears, a custom he considers barbaric, not only because of its origin, and the crude methods by which it is practiced, but for its occasional consequences. Death has resulted from trismus, erysipelas and gangrene, while many observers have reported fibroid growths at the seat of injury, which tend to recur and may become malignant. Thorner reports from his own experience, cases of erysipelas, eczema of the auricle and tumors including fibroma and keloid. These cases lead him to believe that such consequences are more frequent than are usually thought, and he hopes that it will come to be considered an evidence of brutality to have a tender and unprotected child subjected to such an unnecessary and mutilating procedure.—*Jour. Med. Asso.*

### The Etiology of Eczema.

In a paper on this subject read before the Pan American Medical Congress at Washington, Sept. 1893, Dr. A. Ravogli draws the following conclusions:

1. Eczema is a local affection of the epidermis of a chronic inflammatory character, contagious under favorable circumstances.

2. It is caused by pyogenic micro-organisms (staphylococcus pyogenes albus) developed upon a previous inflammation of the skin.

### Treatment of Chorea.

Dr. Abercrombie makes the following suggestions in a clinical lecture concerning the treatment of chorea in children. Unless the attack is very mild, absolute rest of mind and body is essential. Lessons must be given up, and the child kept at home lying down. Most severe attacks demand complete rest in a bed with padded sides. In other severe cases the child should be slung as in a hammock. Only in the lightest attacks should the patient feed himself. When mastication is difficult, minced meat, strong beef-tea, milk, and cocoa should form the chief articles of diet. Sleep is of great importance. If

necessary, chloral hydrate, morphine, or bromides may be administered. Iron and arsenic are the best drugs, though drug treatment is of less importance than general management. Rheumatic manifestations or heart complications should be treated on general principles. In chronic cases douches to the spine, shampooing, massage, and gymnastics are of value.—*The Medical Record.*

### A Bromoform Mixture for Whooping-Cough.

℞ Bromoformi.....mxvi.
Spiritus rectificati.....℥ij.
Glycerini.....℥xij.
Tincturae cardamomi compositae....℥ij.
Mix in the order given.
A teaspoonful to be taken every six hours.

### Signs of Commencing Pericardial Effusion.

In opposition to the almost universally accepted teaching that commencing pericarditis is first manifested by an increase (broadening) of the cardiac dullness at the base of the heart, Ebstein finds that the first alteration occurs in the lower regions of the area of dullness. At first there is a stretching of the pericardium towards the left side, but this is seldom discoverable, partly on account of the occurrence simultaneously of left pleurisy, partly on account of the overlying of the cardiac apex by the lung, partly on account of the loud tympanitic note in the semilunar space. After a short time the pericardial sac will be distended towards the right side also; and this enlargement may be recognized clinically in nearly every case by the appearance of an absolute, or almost absolute, dullness in the fifth right intercostal space in the region named by Ebstein the cardio-hepatic angle (*Herzleberwinkel*). The symptom is all the more demonstrable if it occurs under the observation of the physician, because the possibility of mistaking it for the other processes which bring about complete dullness in this region is entirely excluded. Further, this absolute dullness in the cardio-hepatic angle is of importance for the differential diagnosis between pure hypertrophy of the heart and accumulation of the fluid in the pericardium, because, according to Ebstein, so far as has been hitherto ascertained, absolute heart dullness between the fifth and sixth ribs, even in extreme hypertrophy of the right heart, does not extend beyond the right sternal margin. The cardio-hepatic angle marks also the spot at which, during the retrogression of pericardial effusions, the dullness remains longest observable. A series of clinical histories serves as a proof of the above propositions. —*Virchow's Archiv. Archiv f. Klin. Med.*

### For Laryngeal Phthisis with Dysphagia.

℞ Cocainae hydrochloratis.....gr. x.
Acidi borici.....gr. iv.
Glycerini.....mxv.
Aquae destillatae ad.....℥j.
Misce et fiat applicatio
To be applied to the throat when necessary.

## SURGERY.

### Di-iodoform in Simple Chancre.

Messrs. Hallopeau and Brodier have communicated to the Societe de Therapeutique of Paris their experience in twelve cases of simple chancre treated with dio-iodoform. They arrived at the following conclusions. (1) Di-iodoform may be used in these cases in the same way as iodoform: it generally cures in eighteen to twenty days. (2) It is well borne, and produces neither pain nor local irritation. (3) It has the advantage over iodoform that it gives out no odour, provided it is kept away from the light in well-stoppered bottles. (4) It may, like iodoform, fail to cure in cases of phagedænic chancre. (5) It should be applied several times daily: the ulcer should be kept covered with absorbent cotton-wool impregnated with the drug. (6) It gave good results in a case of lymphangitic abscess of the penis, and generally it is applicable in the treatment of the suppurations and ulcers which are benefited by iodoform dressings.—*Le Progres Medical.*

### An Application for Recent Ringworm.

℞ Thymol.....ʒss.
Chloroformi.....℥ij.
Olei olivae ad.....℥j.
Misce et fiat applicatio.
To be applied night and morning.

## ARMY AND NAVY.

U. S. ARMY FROM MARCH 11, 1894, TO MARCH 17, 1894.

Leave of absence for six months to take effect on or about May 1, 1884, with permission to go beyond the sea is granted Captain Walter W. R. Fisher, assistant surgeon United States Army.

By direction of the president the retirement from active service, March 13, 1894, by operation of law, of Major John H. Bartholf, Surgeon, United States Army, under the provisions of the act of Congress, approved June 30, 1892, is announced.

First Lieutenant Paul F. Straub, assistant Surgeon, United States Army is relieved from duty at Fort Riley, Kansas, and ordered to report in person to the Commanding Officer, San Carlos, Arizona, for duty at that post, relieving First Lieutenant Hurlan E. McVay, Asistant Surgeon United States Army.

Lieutenant McVay, on being relieved by Lieutenant Straub, will report in person to the Commanding officer, Whipple Barracks, A. T., for duty at that post.

A board of officers to consist of Lieutenant Colonel R. Greenleaf, Deputy Surgeon General U. S. Army; Colonel Albert Hartsuff, Deputy Surgeon General, U. S. Army; Major Benjamin F. Pope, Surgeon, is appointed to meet at the call of the president thereof, at San. Francisco, Cal., for the examination of Captain William R. Hall, Assistant Surgeon, with a view of determining his fitness for promotion, as contemplated by the act of Congress, approved October 1, 1890 and July 27, 1892.

Captain Hall will report in person to the president of the board for examination at such time as he may designate.

THE
MEDICAL AND SURGICAL
REPORTER.

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## ORIGINAL ARTICLES.

### EPILEPSY.*

J. A. LARRABEE, M. D., Louisville, Ky.†

Notwithstanding the fact that epilepsy, as a disease, has been described by the oldest medical writers, and that it is in all probability coeval with the oldest history of man, we are as unable to-day to demonstrate its pathology and indicate its cure, as when 2,380 years ago, it was graphically described by the great "father of medicine." The most comprehensive answer to the question, What is epilepsy? is that it is an explosion of nerve-electrical-force, or, in a word, vaso-motor spasm.

With the exception of those instances where traumatism has established an irritating cause, the brain of the epileptic, dissected after death, shows no lesion which could be made to account for the seizures. While there is a marked leaning of medical authorities to hereditacy as a pre-disposing cause, there is very great reason to doubt it and statistics by no means confirm such a theory.

In regard to chronic alcoholism on the part of either parent, statistics are more conclusive and leave very little room to doubt that drunkenness stands in the relation of cause to effect in the production of epileptic children.

Syphilis—that protean hydra of the human race—has also made claims which are not proven. It cannot be doubted that acquired syphilis is productive of serious organic lesions of the nervous system, but epilepsy is not one of these.

That parents of highly nervous organization, hysterical mothers, and neurotics in general, are likely to transmit to their offspring a diathesis favorable to the development of epilepsy, is entirely agreeable to what we know of diabetes and other neuroses.

Statistics gathered from asylums and hospitals show that one-third of all cases of epilepsy in children have begun before the tenth year of life, and that three-fourths of all before the twentieth year.

Hippocrates, nearly three thousand years ago, wrote these words concerning epilepsy, "The cure may be attempted in young persons, but not in old." This paper is based upon the analysis of twenty cases of well established epilepsy, covering a period of seventeen years, and ranging in age from five to twenty-five. All have been cured, or in other words have been entirely free from *grand* or *petit mal*, since treatment, but the recent cases cover now only two and one year of observation. Of course these still remain doubtful. One case, a girl of ten years who had as many as five or six *grand mal* seizures a month, had a severe spell last September, after a whole year of perfect immunity. She is not included in the above number. It is interesting to note that this attack was undoubtedly brought about by a hearty meal of sausage and pork. The mother remembered, better than I, that I had said in my lectures that the child could be allowed to eat meat at the end of the year if she had no spells. On the anniversary of that day she gave the above *menu* for supper. She has again been put on treatment and has had no return up to now.

*Read before Louisville Med.-Chirurg. Soc., Feb. 2nd. 1894

†Prof. Diseases of Children Med. Dept. Central Univ. of Kentucky.

The first case, seventeen years ago, was an adult who was obliged to give up a lucrative position by reason of the frequency of his attacks. He had been treated for years unsuccessfully by bromides and presented the bromidean acne when he came to me. He remained two years under treatment and is now in California and at last accounts well. He was treated with sulphate of copper and had the copper line well marked upon the gums. Six other adults have been discharged and remain well. One treated by gold has had no spells for six months. The remainder were children at and below the age of puberty. One patient still under treatment with chloride of gold and sodium, although markedly benefited, has been obliged to suspend the treatment on account of bowel and stomach derangement. From my limited experience I have found the salts of zinc and gold to be more irritating than the ammon. sulph. of copper, which I prefer.

I believe, that nitrate of silver in small doses continued long enough to produce argyria, will result in the cure of ninety per cent. of epileptics. But the disfiguration is of such a character that it would be unwarrantable practice without a written contract in which the patient agrees to look all through his life like a highly polished stove-pipe. Believing as I do that the metals tin, copper, zinc, and gold all act in the same manner, namely, storage in connection with the nerve cells in the discharging areas of the brain, I have used them with the above results.

Two of my epileptic patients, not included in the above list, have died in a fit. Both could have been saved had any one been present. One, a most estimable lady, was found face down upon the bed; the other fell into a tanner's vat where he was employed. No epileptic should be allowed to sleep on a feather pillow.

In speaking of my treatment of these cases I claim nothing new or original. The therapeutics of epilepsy has included at different periods in the history of medicine nearly every drug and chemical in the materia medica, nor is it strange that a disease, whose pathology is shrouded in mystery, should in ancient times have been the subject of all that is mythical, mysterious, and superstitious in medicine. Not only has the earth and sea been scoured for remedies, and vile and disgusting concoctions made from the animal and vegetable kingdoms but the planetary system has been invoked and the subtle salts of the alchemists have had their day and, what is stranger still, their cures. The charm and the amulet, the mistletoe gathered under the exacting rules of the Druids, have all cured under the dominant idea.

*Bromides:*—The introduction of bromic acid united with various bases marks an important era in infantile therapeutics. This is the "sweet oblivious antidote" dreamed of by the immortal "Bard of Avon" with which we may "erase the writ tablets of the brain." While the bromides are inadequate to the cure of confirmed epilepsy, they are of all agents the best, to obtund the brain to peripheral impressions. Their sphere of action is in the prevention rather than in the cure, and some one of the salts of bromine should be continued for two weeks after a fit of eclampsia in the infant or child. A longer continuation is apt to produce unpleasant symptoms of bromism. Ammonia is the best base for any of the acids, therefore preferable to potash. In adults these agents, carried to their toxical effect, secure often long immunities to a seizure, but only so long as a condition bordering upon imbecility lasts. With a cessation of the drug and a return of the nerve centres to their pristine vigor, the attacks return in full force. It is quite different with the child and some permanent cures may be expected in the growing brain from the administration of bromides.

*Nocturnal Epilepsy, Night Terrors or Nightmare*: The fact that epilepsy may exist for a long time unobserved is important. When a strong healthy man or woman is heard to utter a cry and seen to fall to the ground in a convulsion, attention is attracted to them. When a child stops for a moment at its play and fixes its eyes upon some object, remaining immovable for a moment of time, and then without any other manifestation resumes its play as though nothing had occurred, no attention is paid to it. Such attacks, however, constitute the "*petit mal*" of epilepsy. "Not infrequently children awaken in the morning complaining of violent headache and the soiled and disarranged bedding afford the only evidences of a struggle concerning which the child has no recollection." Such instances are by no means uncommon and their true nature is only revealed by

some fellow occupant who is put to watch them.

The relation of night terrors of children to epilepsy is also a matter of very great importance. This distressing condition often "poohed" at and less frequently but too often made the subject of chastisement, has a marked effect upon the growing brain and forms the background in the history of many an adult epileptic. Children who by inheritance are possessed of a neurotic diathesis are more prone to such attacks.

When such authorities as Hennock, of Berlin, and Goodheart, of London, make the statement that they do not consider food to be a factor of any prominence in the etiology of night terrors, it may seem presumptuous for me to compare my limited opportunities of experience with their extensive observation. Nevertheless an honest difference of opinion, however humble the source, is offered in the spirit of truthful investigation. From that experience I am forced to conclude that not only certain foods, but also the time at which they are taken, has largely to do with the production of night terrors and consequently with the development of epilepsy in childhood. I have met with very few where the night terrors were not traceable to injesta in the intestinal tract and with none in which a regulation of diet, especially the last meal, did not inaugurate an improvement and an amelioration of the night attacks.

Nitrogen is an essential element in gun powder and other explosives with the destructive force of which we are only too familiar. It is scarcely less dangerous and destructive when circulating to an excess in the blood of animals whose nerve force it has the power of suddenly discharging. Epilepsy may be produced at will in the young of even carnivorous animals by feeding raw meat during the period—(formative)—of lactation. Kittens so fed, will develop fits in a few days which prove fatal if continued, but which cease with the withdrawal of the meat. Horses over-fed with stimulating, nitrogenous foods, have epilepsy and fall trembling in the harness. A piece of raw beef steak with tea or coffee at supper will be as equally certain to cause an uproar in the nursery during the night.

It is a suggestive fact that the brightest minds that have adorned our nation, and the greatest statesmen who have figured in history, were put to bed as children upon bread and milk or oaten porridge. Whether or not the "meat and morals" of the great Russian reformer Tolstoi, shall receive scientific endorsement is yet to been seen, but quiet sleep and brain rest in children are both incompatible with meat, tea and coffee. Nine-tenths of all the various convulsive manifestations in infancy and childhood have their origin in intestinal irritation or from a loaded bowel, packed cæcum or intestinal worms.

I can remember when I used to prescribe bromide, chloral, sulphonal, etc., for the muscular, gastrocnemius cramps of elderly people, with some temporary benefit. Latterly, however, I have found much in common between childhood and age. I find that an acid condition of the jejunum and ileum from faulty assimulation of faulty food is the cause of the acidity, and I have also found that a simple alkali, as soda bicarb., taken on retiring secures exemption from the trouble.

The intellectual status of confirmed epileptics is often a matter of astonishment when we take into consideration the apparent gravity of the seizures. When an explosion occurs in one of the discharging areas of the brain, the senses are under shock and a condition like concussion occurs in the centers of conscious thought. Nearly always, before the suspension of consciousness, the victim ejaculates a word or sentence, which word or sentence remains peculiar to the individual, and then immediately the memory is obliterated. Often the aura is through one of the special senses, as vision, smell or peripheral irritation. The same object is seen, the same odor is smelled and the same peripheral zone is felt before each seizure. My experience among children leads me to indicate more frequently an ocular spectacle which is remembered as a ray of light approaching and blinding the victim. As regards the vigor of the intellect of epileptics, it must be admitted that in the growing age it is impaired by the attacks and often results in imbecility, while in age memory becomes almost entirely obliterated and the various manifestations of softening occur.

The fact that some of the world's greatest masters have been life-long epileptics must not be forgotten. The greatest epochs in history have been inaugurated by epileptics, while poet have sung and martyrs have suffered unde

its strange hallucinations. Upwards of a hundred millions of the world's population to-day bow the knee as devotees to the erratic religious devotions of an epileptic, whose prophetic visions and vagaries were but a part of his epilepsy. The old Roman wall of England, the broken arches upon the Rhine, the lofty peaks of Cis-Alpine Gaul bear silent witness to the indomitable will, fortitude and genius of an epileptic, who lived before the Christian Era; while in the still remembered years of modern history we recall the burning of Moscow, the carnage of Austerlitz and Jena, and the culminating battle of Waterloo as the work of an epileptic whose gigantic intellect was extinguished amid the tempest of that awful night at St. Helena.

Persons who develop epilepsy after the age of puberty appear to retain their mental vigor in the interval of the attacks, and are often capable of attending to all the duties of life. They are moreover possessed of strong will power and determination. If a religious trend has been given to their character, they become very devout, often fanatical, and make sacrifices which would be quite impossible for ordinary individuals.

Confirmed epileptics often enjoy immunity to attacks by a pre-occupancy of the mind or by engagements in hazardous undertakings, e. g. A famous church spire painter who worked in Louisville was an epileptic, and could be seen any day suspended upon his airy platform 150 feet above the ground. He never had a spell while aloft pursuing his work, but once back upon *terra firma* he would be seized with a fit. So marked is this feature that treatment by a new physician, especially if he be a celebrity, often secures a long immunity to the seizures. The knowledge of this fact should caution us against attributing the relief to our therapeutic measures.

Epileptics seldom die in a paroxysm but oftener live long and useful lives. A gentleman well known in this city and throughout the state, whose Christian example and good works will be handed down to future generations, has been an epileptic from boyhood. He was refused life insurance over 40 years ago and has outlived every one of the agents and physicians of the company. He has been twice paralyzed, first right and then left hemiplegia, and is to-day a sound reasoner and thinker.

I desire to call especial attention to the importance of the treatment of infantile eclampsia. The commonly accepted fact that convulsions—epileptiform—are of frequent occurrence in inverse proportion to age, may possibly be the cause of carelessness in general practice, the consequences and the importance of a complete restoration of the nerve centres is forgotten. The foundation for future epilepsy is thus laid. This is about the way it runs: The family physician is called to a child in a fit, he arrives—is informed that it is all over—the child has had a spasm but is now sleeping quietly; if he wishes he can come in and see it. Now, instead of explaining to the friends the importance of after treatment, care, diet and possible medication, he is too apt to say, "Oh, never mind, I guess it will be all right, and if he has any more trouble let me know."

The increasing tendency to convulsions in infancy may be attribued to two principal causes, namely, first, the more perfect development of the animal brain—cerebellum; second, the immature development of the intellectual brain—cerebrum.

All the acts and functions of the new born babe are reflex, rythmical only becoming manifest with the deposit of gray matter, e. g., Cheyne-Stokes respiration denotes serious disease in a child and adult, but it is the normal respiration of an infant. The pulse has no regularity and noise and slight concussion are responded to, as in a frog poisoned by strychnine. Gradually, however, the will power "that column of true majesty in man" develops and asserts its power over the spinal system. Just in proportion to this development or non-development an infant remains liable to convulsions. Every practicing physician knows of families possessed of such a diathesis and learns that a hasty summons on account of some trifling ailment means a spasm. A child who has had a convulsion from any of these causes is more liable to have another from a lesser cause and so on until finally a "status epileptica" is established, after which the fits occur without any apparent cause. We know comparatively little of the process by which such photographic impressions are made upon the growing brain of the infant, but we do know that the stains are well nigh indelible.

# COMMUNICATIONS.

## DENTITION WITH DISEASES OF THE TEETH AS A CAUSE OF EAR DISEASE.

LAURENCE TURNBULL,* M. D.

Every physician of experience has found that eruption of the teeth is a cause of earache, followed by pain and a discharge of pus and a laceration of the drum membrane. Especially so when (as frequently happens) the teeth are so impacted that they cannot erupt, if not relieved by lancing the gums. Again the so-called wisdom teeth, from their reflex irritation and pressure, are a cause of deafness and should be removed. Caries of the teeth, caused by acids and fungi (lepothrix fuocatis), is usually attended by both toothache and earache from extension into the ear by the Eustachian tube. The gums, buccal cavity and alveolar processes are rich in blood vessels and nerve filaments from the fifth pair to each, and the whole of the nerves which are spread over the jaw bones, both upper and lower.

If children and adults are of feeble frame and the vitality is lowered by constitutional diseases like syphilis, scrofula or consumption, the teeth are generally of a chalky, white color, brittle or soft, and decay with great rapidity by the action of the *lepothrix* living on carious stumps, which decay impairs digestion and nutrition. When a "cold is taken," these stumps being dead, there is almost always an attendent coryza. This affects the ears, causing a "running ear" better known by the term otorrhœa, but more correctly as an acute otitis media catarrhalis or purulentia. Trophic changes also occur in the Eustachian tube or middle ear with alveolar abscess or with disease of the antrum of Highmore. The nasal mucous membrane is also a fruitful cause of ear trouble.

The accretion on the teeth known by the popular name tartar—properly named calculus—is a deposit of lime salts from the saliva. Among the secretions of the salivary glands, that of the parotid alone may be feebly acid; that of the submaxillary and sublingual glands is, on the contrary, constantly alkaline. This fact has been proved by the aid of sounds introduced into the efferent canals of these glands. The secretion of the parotid is sometimes acid when first collected; but this reaction passes promptly to the neutral state, or to one slightly alkaline, when the liquid loses the clearness which it possessed at first. This acid reaction arises, according to M. Oehl,† from the carbonic acid absorbed in the liquid, which holds in solution the carbonate of lime with which the liquid secreted by the parotid is abundantly provided. When carbonic acid disappears, the acid reaction ceases to take place and the carbonate of lime which it holds in solution is precipitated.

"This circumstance explains the formation of the tartar upon the teeth. The fact that this sometimes contains a large quanity of phosphate of lime at the same time with the carbonate, is not in contradiction with this explanation, inasmuch as the carbonic acid may hold phosphate as well as carbonate of lime in solution. The precipitates of the calcareous salts inclose numerous elements of *leptothrix* and of other products which are met with in the mucosities of the mouth, such as epithelial cells, leucocytes, etc."‡

The tartar, it is stated, protects the tooth substance, but by pressing away the gum and causing absorption of the process, it causes irritation and loosening of the teeth, and gives rise to changes in color and healthy character of the gums, and the whole buccal mucous membrane; this red condition extending into the throat and ear is often an indication of disease of the bronchial tubes and lungs.

We leave the matter of getting rid of dental diseases, caries, calculi, etc., to the competent dentists of the present day, having every confidence in their judg-

*Aural Surgeon to the Jefferson College Hospital, etc., Philadelphia.

†La saliva humana, etc. Pavia, 1864. Vide Meissner's Jahresber. (Meissner's Annalen f. rat. Med. xxv., Bd. 2. H., S., 242).

‡ Dental Caries, Drs. Leber and Rottenstein, p. 87. Trans. by T. H. Chandler.

ment in all matters connected with their specialty.

We add from long experience as a physician some most judicious advice on the care of the teeth. Our first object should be the use of prophylactics, and by avoiding strong acids, to get rid of those which are formed in the mouth by fermentation or sepsis, and prevent the growth of the fungi, which are of the same nature as those which are found in the ear. Rub the teeth and gums night and morning, using a moderately hard brush and water with pure castile soap; this produces a slightly alkaline solution, which should be applied well to the teeth. In some cases the soap is not quite alkaline enough, then the addition of a portion of the bicarbonate of soda on the brush; or, if a stronger agent is required, a solution of permanganate of potassium in water (grain 1 to the ounce) will be found a most valuable antiseptic. Care must be taken that no metallic substance or foreign body should come in contact with this salt, as it gives up its oxygen and becomes decomposed. A glass dropper and glass stopper is always necessary in using so delicate an article. This is to be followed by a fine tooth powder, not gritty, made of chalk and orris root, with a few drops of perfume.

In hospital and surgical practice a solution of the permanganate (24 grains to the ounce) is usually kept on hand as an antiseptic, deodorant and detergent. Of this solution half a drachm, or thirty drops, may be added to a pint of boiling water, this can be used in the nose, mouth, throat and ear, when there is a discharge of pus from the meatus.

In passing we would simply state our personal experience in regard to dental plates. These should be of gold, platinum and dark vulcanite. Certain forms of vulcanite colored by mercury (vermillion) we have found to produce disease of the gums and buccal cavity extending to the ear, notwithstanding, it is stated that "pure sulphuret of mercury fused in vulcanite is reckoned by Orfila as medicinally inert."§ Every plate of this kind should be removed at night and brushed in soap and water.

In regard to fillings, we prefer gold but there are cases in which gold cannot be used; then a soft material should be used free from acids and mercury. In modern dentistry cements of zinc oxide and glacial phosphoric acid should be used and are universally approved. So are amalgam fillings, but all mercury must be carefully avoided. If the tooth or teeth are very defective from caries — extending into the roots—their removal is usually an absolute necessity, and fitting by a plate or plates should follow. Dentists do not consider teeth hopelessly gone so long as the roots remain firm and capable of being cleansed and rendered aseptic, so that pivot teeth can be fitted to them. It is otherwise, of course, when there is chronic abscess, or decay has extended beyond the pulp cavity into the root body.

The following is a list of some of the diseases of the ear due in part or wholly to reflex irritation of the teeth: Acute and chronic catarrhal inflammation of the middle ear; acute, subacute and chronic purulent inflammation of the middle ear; otitis externa, alveolar abscess, and ozœna. Sometimes we have found the metal filling forced down into the jaw by too great a pressure of the mallets, which are now used, and in one case such was the cause of profound deafness; hearing was improved after the removal of the pressure. Such a case as this, however, is fairly to be charged to malpractice. No dentist should dream of packing gold or other metal in the apices of the roots; the apices may be closed with other kinds of stopping, is (none of which ought to be, nor usually is, so forced as to extrude), and *then* the body of the root is filled with gold or other material.

§Harris' Practice of Dentistry

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He Knew What He Wanted.—Newspaper Clerk: "Your advertisement reads: 'Wanted, a little girl to mind a baby. Don't you think it would sound better if it read like this: 'Wanted, a little girl to care for a baby?'"

Advertiser—"No. Mind is the correct word. You don't know that baby."—*Judge.*

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Bacon—Does not phrenology apply to the animal kingdom? Professor—certainly. There are animals with well defined humps. "Camels, for instance," —*Yonkers Statesman.*

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It is said that God sees everything, but what use can he see in a cigarette smoking dude?

# SOME ANATOMICAL AND SURGICAL RELATIONS OF THE PARTS INVOLVED IN THE OPERATION OF INTRA-CRANIAL NEURECTOMY OF THE FIFTH PAIR OF NERVES AND REMOVAL OF THE GASSERIAN GANGLION.*

WILLIAM J. TAYLOR, M. D.,†

Intra-cranial neurectomy of the fifth nerve and the removal or destruction of the Gasserian ganglion must now be given its place as one of the most brilliant and difficult operations in surgery.

Rose and Hartley have given us very definite directions as to the mode of opening the skull and general surgical technique, but I have failed to find an exact statement by anyone of the relative positions of the foramina, the ganglion, and arteries. It is with the hope of adding to our knowledge of these anatomical and surgical relations that, at the suggestion of Dr. W. W. Keen, I have lately made a careful study of the interior of twenty skulls taken in the most part from the collection in the Mutter Museum of the College of Physicians. My aim has been to establish by accurate measurements the distance between the foramina of exit of the second and third branches and to establish definitely their relationship with the foramen spinosum, the carotid canal, and the depression or fossa for the ganglion. As is well known this ganglion, a reddish-gray band of ganglionic matter slightly curved in its long axis so as to present a convexity forward and outward, rests upon a depression in the petrous portion of the temporal bone. From the convex antero-external border, three large bundles of nerve fibres arise.

The *first* or ophthalmic division is the smallest and is purely sensory in function. It arises from the upper portion of the ganglion, enters the cavernous sinus, and passes forward in contact with the outer wall of the cavernous sinus, through the sphenoidal fissure into the orbit.

The *second* or superior maxillary division, also a sensory nerve, passes out through the foramen rotundum and enters the orbit through the spheno-maxillary fissure.

The *third* or inferior maxillary, the largest of the three divisions, consists of two portions: the larger or sensory root arising from the inferior angle of the ganglion, and the smaller or motor root passes beneath the ganglion. This latter accompanies the sensory root and joins it after it emerges from the foramen ovale.

A small branch, the *recurrent*, passes into the cranium through the foramen spinosum along with the middle meningeal artery. This divides into two small branches to be distributed to the dura mater and to the lining membrane of the mastoid cells.

As will be seen by this short account of the three divisions of the fifth nerve, it is impossible to make a definite section of the first division without doing great damage to the cavernous sinus, the third, fourth, and sixth nerves, and the carotid artery.

We must be contented to cut the attachments and remove or destroy the ganglion, and with it the second and third division as they pass through the foramen rotundum and foramen ovale.

The middle meningeal artery as it enters the cranium through the foramen spinosum must frequently be wounded or torn through in our endeavors to reach the ganglion. For this reason it is often wiser to ligate and deliberately cut it than to run the risk of tearing it as it passes through the foramen; when by any chance this occurs our only means of controlling the hemorrhage is by packing the foramen or the ligation of the external carotid artery below the origin of the internal maxillary artery.

In this examination for convenience, and because it is a measure with which we are all familiar, I have taken the inch and its subdivisions of sixteenths as the most readily understood and easiest obtained unit of comparison.

*Read before Phila. Co. Med. Soc. February, 14, 1894.

†Professor of Orthopædic Surgery in the Philadelphia Polyclinic; Attending Surgeon to St. Agnes Hospital; Assistant Surgeon to the Orthopædic Hospital and Infirmary for Nervous Diseases.

*First.* I have measured the distance, centre to centre, from the foramen spinosum to the foramen ovale; from the foramen ovale to the foramen rotundum, and from the foramen spinosum to the foramen rotundum.

*Second.* I have measured centre to centre, the distance by which the foramen ovale is in front of the foramen spinosum, taking the sides of an imaginary parallelogram, the foramen spinosum being the external and posterior, and the foramen rotundum the anterior and external points.

Also, the distance by which the foramen ovale is internal to the foramen spinosum, the distance by which the foramen rotundum is anterior to the foramen spinosum, and the distance by which the foramen rotundum is internal to the foramen spinosum.

*Third.* The diameters of the three foramina—spinosum, ovale, and rotundum.

*Fourth.* The distance between the centre of the foramen rotundum and the depression or fossa for the ganglion, and from the center of the foramen ovale to this fossa for the ganglion.

*Fifth.* The width of the bridge of bone between the foramen ovale and the carotid canal.

In going over these skulls carefully I have found such a great inequality in the measurements between the two sides that I have made a definite note of these variations, and give in my table the greatest, the least, and the mean measurements. Possibly a better understanding of the system of measurements may be gained by a glance at Fig. 1, which shows the relative positions of foramina, etc.

I have also had made a series of twelve photographs, and of these have selected four of the most typical. In these the inequality is seen most distinctly.

The distance between the centre of the foramen spinosum and the centre of the foramen ovale varies from 2 to 9, with a mean distance of about $4\frac{11}{16}$ sixteenths of an inch.

The centre of the foramen ovale to the centre of the foramen rotundum varies from 6 to 13, with an average of between $9\frac{5}{16}$ and $10\frac{7}{16}$ sixteenths of an inch.

The centre of the foramen spinosum to the centre of the foramen rotundum varies from 8 to 17, with an average of between $13\frac{5}{16}$ and $14\frac{11}{16}$ sixteenths of an inch.

The centre of the foramen ovale is anterior to the centre of the foramen spinosum from 2 to 6, with an average of from $3\frac{5}{16}$ to $3\frac{7}{16}$ sixteenths of an inch.

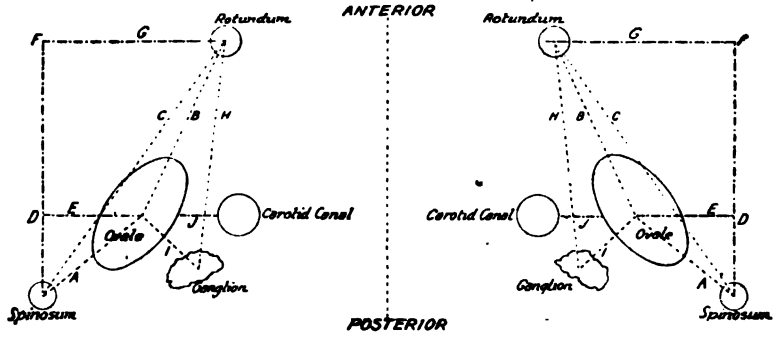
The centre of the foramen ovale is internal to the centre of the foramen spinosum from 2 to 6, with an average of from $3\frac{5}{16}$ to $3\frac{11}{16}$ sixteenths of an inch.

The centre of the foramen rotundum is anterior to the centre of the foramen spinosum from 9 to 14, with an average of from $11\frac{5}{8}$ to 12 sixteenths of an inch.

The centre of the foramen rotundum is internal to the centre of the foramen spinosum from 4 to 11, with an average of from $7\frac{11}{16}$ to $8\frac{1}{16}$ sixteenths of an inch.

The distance from the centre of the foramen rotundum to the centre of the

FIG. 1.



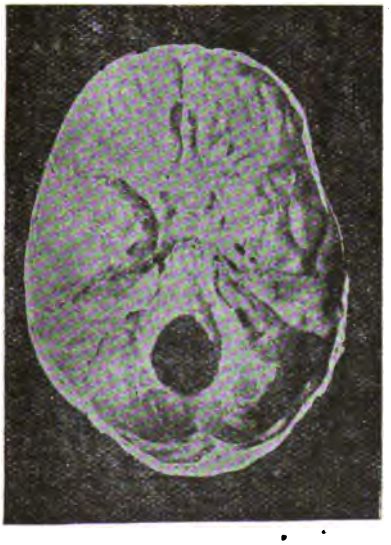

*A*, Spinosum to ovale. *B*, Ovale to rotundum. *C*, Spinosum to rotundum. *D*, Ovale anterior to spinosum. *E*, Ovale internal to spinosum. *F*, Rotundum anterior to spinosum. *G*, Rotundum internal to spinosum. *H*, Rotundum to ganglion. *I*, Ovale to ganglion. *J*, Bridge of bone between foramen ovale and carotid canal.

fossa for the Gasserian ganglion varies from 8 to 16, with an average distance of between 13 and $13\frac{6}{16}$ sixteenths of an inch.

FIG. 2.

The centre of the foramen ovale is distant from the centre of the fossa or groove for the ganglion from 2 to 9, with an average distance of $5\frac{1}{16}$ sixteenths of an inch.

FIG. 4.

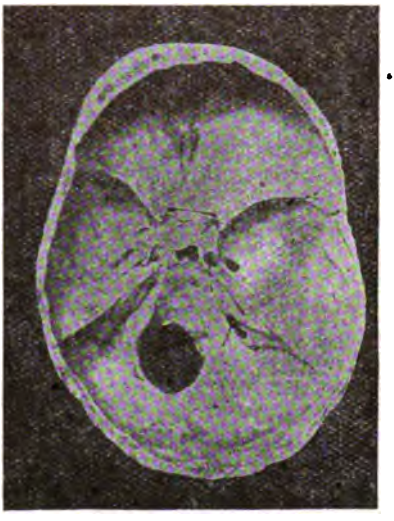


The width of the bridge of bone between the foramen ovale and the carotid canal varies from 1 to 9, with an average width of from $4\frac{1}{16}$ to $5\frac{1}{16}$ sixteenths of an inch.

The diameters of the foramina have been determined to be as follows:

The *spinosum* varies from less than 1 to 3, with an average of from $1\frac{2}{16}$ to

FIG. 3.

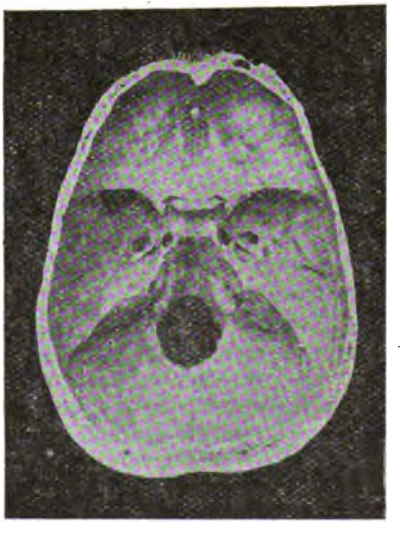


$1\frac{13}{16}$ sixteenths of an inch.

The *ovale* varies from 3 to 6, with an average of $4\frac{13}{16}$ of an inch.

The *rotundum* varies from 1 to 3, with an average of between $2\frac{1}{16}$ and $2\frac{3}{16}$ six-

FIG. 5.



teenths of an inch in diameter.

It will be seen by these measurements, and by a glance at the accompanying photographs and table, that the relation-

ship between these different points is by no means constant, and in operating we must realize the fact. In the majority of instances the foramen spinosum with the middle meningeal artery is far enough away from the foramen ovale and the third branch of the nerve, to enable us successfully to cut the latter without wounding the bloodvessel. This is particularly marked in Fig. 4, on the left side, where the distance is $\frac{2}{16}$ of an inch. On the other hand, the spinosum may be so nearly in a line with the ovale that to reach it without wounding the middle meningeal artery would be impossible. In some of the reported cases of

The rotundum is most constant in its shape and its variations are of little importance to the surgeon.

The spinosum varies much, and in one instance (Fig. 3), as is well shown in the photograph, there are two distinct foramina on the left side.

The character and sex of the skull seem to have little bearing upon the relative position of the foramina, with the exception that a broad, flat skull usually shows a greater distance between them, and it has been impossible to fix upon any rule by which these variations may be anticipated.

---

AVERAGE MEASUREMENT OF TWENTY SKULLS, RIGHT AND LEFT SIDES.

| | Centre to centre. | | | Centre to centre. | | | | Diameter. | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 Sp. to Ov. | 2 Ov. to R. | 3 Sp. to R. | 4 Ov. ant. to spin. | 5 Ov. ant. to spin. | 6 R. ant. to spin. | 7 R int. to spin. | 8 Spin. | 9 Oval. | 10. Rot. | 11 Rot. to gang. | 12 Ov. to gang. | 13 Ov. to carotid canal. width bridge of bone. |
| Av'r'ge 20 sk'lls Right, | 4 15-20 | 10 7-20 | 14 12-20 | 3 4-20 | 3 11-20 | 12 00 | 7 13-20 | 1 12-20 | 4 16-20 | 2 2-20 | 13 6-20 | 5 12-20 | 5 1-20 |
| Left, | 4 14-20 | 9 9-20 | 13 2-20 | 3 7-20 | 3 9-20 | 11 10-20 | 8 11-20 | 1 9-20 | 4 16 20 | 2 1-20 | 13.00 | 5 12-20 | 4 13-20 |
| Sm'l'st 20 sk'lls Right, | 2 | 8 | 12 | 2 | 2 | 9 | 4 | 1 | 4 | 1 | 10 | 2 | 1 |
| Left, | 2 | 6 | 8 | 2 | 2 | 9 | 4 | 1— | 3 | 1 | 8 | 2 | 1 |
| Larg'st 20 sk'lls Right, | 7 | 13 | 17 | 6 | 5 | 13 | 11 | 2X | 6 | 3 | 16 | 9 | 9 |
| Left, | 9 | 11 | 17 | 6 | 6 | 14 | 10 | 3 | 6 | 3 | 16 | 8 | 8 |

the operation, where mention is made of alarming hemorrhage, I am convinced this state of affairs existed.

For this reason, whenever the exposure of the third branch of the nerve is at all difficult, the surgeon should at once search for, ligature the artery, and cut it across, before attempting to find the nerve. This ligation of this artery is not very difficult, and will at once give much greater freedom of action.

The size and shape of the foramina vary in different skulls; especially is this so with the ovale, which is at times perfectly round.

IN spite of the suspicion which attaches in many minds to the use of "hyponotic suggestion," its therapeutic practice seems to be rapidly gaining ground in this country. Not long ago the British Medical Association, after hesitating for a year, found itself compelled to "receive" the favorable report of the committee it appointed to investigate the matter, and it is noticeable that the tone of the medical journals has gradually changed from one of open hostility to a more or less favorable tolerance.—*London Public Opinion.*

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EVERY man has as much right to kill himself as he has to live a useless life.

# AMERICAN GRIPPE, OR MYXOIDŒDEMA.*

CARL SEILER, M. D., PHILADELPHIA.

I have been asked to present my observations of American grippe and its after-effects. Of course, the subject is one which is so interesting to all of us, and which is, unfortunately, so mixed in the minds of many, that it will be possible for me, in the short time, to give only a *résumé* of the subject. Therefore I hope that the few remarks that I shall make may be of sufficient interest to the members of the Society to call forth their expression of opinion and relation of clinical observations of much more value than my own.

In 1885 I observed the first case of this peculiar disease. I afterward (in 1887) discussed the subject with Dr. Glasgow, of St. Louis, who, strange to say, had made observations similar to my own; and as there was no disease which had been described which, to our knowledge, came anywhere near the one under discussion, he had called it "It," and so had I. The disease was first described by me in a paper published in April, 1889. Dr. Glasgow reported his observation to the American Laryngological Association in May, 1889, and in June of the same year I read my paper before the American Medical Association as its meeting at Newport. You may remember that at that time I referred to the fact that the disease was spreading all over the country, and that I had received letters from Montana, Washington, the Canadas, from the South, and, in short, from all directions, after having made inquiry about the new disease. Geographic situation, elevation, temperature, and atmospheric conditions apparently had nothing to do with its causation; in fact, the disease was everywhere the same in its specific characteristics.

In 1889, in the month of December, the disease broke out in New York City, where it assumed the proportions of a very alarming epidemic, and its existence was recognized as an epidemic general and fatal all over the United States within a very few weeks after its recognition in New York. Unfortunately it was called "la grippe," or the Russian influenza, a disease differing entirely in its clinical character and prominent pathological lesions from the disease erroneously named by the public press. I then published a paper in March, 1890, in which I gave the differential diagnosis between the Russian influenza, or "la grippe," as well as of other diseases mistaken for it, and the American disease. Last March (1893) I published the fourth edition of my book on *Diseases of the Throat*, in which I devoted an entire chapter to the consideration of this disease, under the name of "American grip," or myxoid-œdema, to distinguish it from the "Russian" or European influenza. The distinction is similar to that which we are accustomed to make between measles and German measles, or morbilli and rubella (Rötheln).

The peculiar symptoms of the American grip are: the sudden onset; the rheumatic pains, in all parts of the body, accompanying the sudden onset; an abrupt rise in the temperature, with moist skin; a peculiar tension; no inflammation of mucous membranes. In some cases a deposit of pseudo-membrane occurs upon the tonsils and elsewhere, which, however, is of entirely different character from the pseudo-membrane of croup and of diphtheria. There is a peculiar puffiness of the mucous membranes, which shows itself wherever the deposit is most developed. It occurs in the throat, in the larynx and nose, in the bronchial tubes, and in the mucous membrane of the intestinal tract. In its prostration of the vital powers of the body the disease is something like typhoid fever; but with it there is no fever, no exacerbation of high temperature; there is no thirst, no dryness of the skin, and no brown coating of the tongue. In one case the temperture was 105° F. at the beginning, but it went down to normal in twenty-four hours. The pulse was 76 right along, and had none of the characters of a fever pulse. In those cases in which death occurred the temperature was reduced to normal, or even subnormal, and the giving out of the heart was the original cause of death.

*Read before Phila. Co. Med. Soc. February 28, 1894.

In some cases the submucous infiltration is most evident in the vocal bands, and here the consequent closing up of the larynx causes suffocation. The immediate cause of death is usually a small hemorrhage in the mucous membrane in such cases. Ecchymotic spots are often observed in the throat, bronchial tubes, and also in the stomach and intestines. Indeed, there may be black vomit, like the black vomit of yellow fever, and the stools may also show the presence of effused blood.

I am now speaking of the symptoms of American grip. I need not refer to the symptoms of Russian grippe, since I could not add anything to the admirable review of them given by my friend, Dr. J. C. Wilson, in his article on "Epidemic Influenza," in Pepper's *System of Medicine*, which you are already familiar with.

In the matter of treatment I have found the greatest benefit from a long-discarded drug—which, I must admit, is of no use in any other disease—the benzoate of sodium. In American grip it acts as a specific, precisely as quinine acts in malarial fever. It relieves the pain at once; it brings down the temperature; it relieves the oppression of breathing, and removes the false membrane from the throat. This remedy, with alcohol and rest, constitutes the whole treatment of the disease. In my experience I have found that it is an absolute specific—of course, provided that the diagnosis had been correct. As to other drugs, I would say that all those patent coal-tar remedies are only a cause of death. They act as heart depressors, when the heart is already profoundly depressed by the disease. Antipyrine, antifebrin, and all the other antis are worse than useless. The heart needs to be supported, and they all cause further depression. Quinine is often a cause of insanity and suicide. During the last three years I have made a careful investigation of all published cases, whenever possible, where insanity had been the cause of death in grippe, and I found that quinine in large doses had always been given to the patients. I have observed, in my own cases, that even very small doses of quinine will often cause mental disturbance.

Thus far I have considered only the acute condition. If benzoate of soda is not given, and the patient does not remain in bed, a chronic condition of grippe will be produced. This is a very distressing condition, as I know from personal experience. The symptoms are so different that they cannot be given in detail, and it is difficult to make a diagnosis. There is a flabby, pale, or coated tongue, want of appetite, impaired digestion, irregularity of bowels. With this there is a depression of spirits, want of ambition, and inability to perform any work requiring exertion of mind or body. A little overexertion will throw the patient back, and it will be days and days before he can regain his former position and begin to gain strength.

The pathology of the chronic cases has been shown to be a slow process of fatty degeneration of all the organs of the body except the kidneys. And, if there has not been pre-existing disease of the kidneys, there will be no albumin in the urine.

The chief symptoms of the chronic form are general neurasthenia, associated with chronic distention of the venuoles, and anæmia of the arterioles throughout the body. This was seen by ophthalmoscopic examination in the eyes, when it produced impaired vision or blindness. Blueness of the skin is due to the same venous congestion, evidently of neurotic origin. Besides the mental depression, there are hallucinations of peculiar character and irritability of temper. Light has a depressing effect, while darkness causes exaltation. Toward evening the patient usually feels much better than in the early part of the day. I have observed that a patient may go to sleep at ten o'clock and wake up at eleven in a state of mental exaltation. He feels like getting out of bed and walking about his room, or relieve his mind by writing poetry; this is the only thing that will enable him to go to sleep again. I have some very curious specimens of this "grip poetry" in my possession. The irritability of temper I have referred to is beyond the control of the patient, although he is fully aware of it; this is part of a hysterical condition, and under slight exertion or emotion, a condition of hysterical aphonia may be developed even in men. Then, again, the patient is very much disturbed by all kinds of rhythmical noises, especially at the seashore, where the "one, two, three" of the breakers nearly drives him out of his senses. Even if he cannot hear them, he is conscious of annoyance from the rhythmical repetition

of the waves, and this will make him extremely nervous, so that he cannot sleep. The rapid succession of the trolley-car bells are also very annoying, and I have had patients who were driven out of the city by these noises.

The treatment of the chronic grip is by alterative tonics. Buchu may be given as a mild diuretic. If there is sleeplessness, bromides are useful. All the coal-tar preparations are bad. Of the narcotics, the best is hyoscine in small doses; as a tonic, strychnine in considerable doses, beginning with gr. $\frac{1}{32}$ up to gr. $\frac{1}{16}$ three or four times a day. A change of climate is advisable, and the best I have found is a moderately high place, where there is plenty of oxygen and an absence of noise. Mineral waters are valuable, and I found at Bedford great advantage from the use of the water, but there is a spring at Swift-water, near Pocono, which I consider even better.

The wine of coca is especially useful when the patient begins to exercise as a "pick-me-up." I came across, the other day, a sample of wine of coca made by the Columbia Chemical Company of Washington City, which I found very much better than any I had previously met with, as it gave much satisfaction in the cases for which I had ordered it. Where the patient must keep at his work the coca is a valuable remedy, as in the case of a preacher who has not suffiient strength to go through with his sermon without some such aid.

## REMOVAL OF THE GASSERIAN GANGLION.

It seems still to be a disputed point whether or not the Gasserian ganglion can be removed. So far as we are able to judge, there is nothing that can be regarded as absolute proof that more than a small part of it has been removed in cases of severe neuralgia in which the nerve has been attacked so near its origin; but whether it is removed or not is a matter more theoretical than of practical interest so long as the cases which are operated upon are relieved of the pain which render their lives a burden.

The operation designed and most skillfully carried out by Mr. William Rose consists in exposing the outer surface of the foramen ovale and applying the trephine to this part of the wing of the sphenoid and so exposing and removing the anterior and outer part of the Gasserian ganglion. His operations have been attended with a very gratifying amount of success. It is a severe procedure, and not unattended with difficulty.

Other ways of reaching the ganglion have been suggested, notably Mr. Victor Horsley's. A very useful modification of the operation has been introduced by an American surgeon, Mr. Hartley, which he described, together with a case on which he operated. Briefly it may be stated as consisting in reflecting the tissues, including the bone, over the temple, the base of the initial curved incision being over the zygoma, and the flap being reflected downwards.

Broad retractors are used to raise the dura mater with the brain, the foramen rotundum and foramen ovale are exposed, the nerves are traced back to the ganglion, and it and the nerves between it and the foramina are excised.

Dr. Tiffany, of Baltimore, in a recent number of the *Annals of Surgery* calls attention to the method and gives particulars of four cases operated upon by it. His cases all did well, apparently; of the four, three have since been observed. In one of the cases, seen 13 months after operation, there was no return of pain, nor was there any pain in the other two, in which, however, only a few months had elapsed since operation. The fourth patient was not seen after he had left the hospital. In the three cases examined it is interesting to find that the persistently anæsthetic freas were very similar. There was a large area around the mouth and over the aace and the lower part of the nose, and another smaller area in the temporal region. Taste was normal in all three cases; a little discomfort was caused by the food lodging between the gum and cheek, a result apparently of the division of the motor branch of the fifth. It may be mentioned that in all these cases the superior branch of the fifth was left alone, and no trophic troubles, ocular or of any other kind, ensued. It is yet too early to be certain that the pain will not return. It is to be hoped that it will not, but, as is well known, even a year of freedom is no guarantee in such cases of an absolute cure.—*The Lancet*, 1894.

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SATURDAY, MARCH 31, 1894.

## EDITORIAL.

### MEDICAL EXPERTS AND THE VALUE OF THEIR TESTIMONY.

The medical expert question should be one of great interest to the profession. No physician is exempt from being called into our courts to testify in cases in which important personal and community interests, often human life, are involved. It is presumed that the physician's greater opportunities for observation and closer study respecting the subjects pertaining to his profession, give superior skill in relation to those subjects and entitle his opinions to be received as those of an expert. Courts have laid it down as a definite rule, that an expert must have made the subject upon which he gives his opinion a matter of particular study, practice, or observation, and he must have particular and special knowledge on the subject. The facts to which he testifies must be scientific facts, as near as it is possible for human knowledge to reach, and not mere theoretical fancies.

Expert opinion is only taken upon questions of science, skill or trade, or others of like kind, or when the subject matter of inquiry is such that inexperienced persons are unlikely to prove capable of forming correct judgment upon it without such assistance, or when it so far partakes of the nature of a science as to require a course of previous study.

The very notion of a science springs from the recognition of the existence of general truths and laws, to which the relation of things to, and their operation upon, each other conform. These laws or truths, ascertained by the investigation of men devoted to particular departments of inquiry, constitute a science. In all the different branches of knowledge different degrees of certainty are attained.

Generally those who appear in our courts as experts are volunteer theorists. The stake in the cases in which they testify is often enormous—it is life, liberty, or large estate—and the *temptations* are *made correspondingly strong*. A theory is to be proven and each party looks around for

some expert to prove such theories. Each party will call only the experts that will prove his case. For good and sufficient consideration there is no difficulty in finding a *ready-made* expert. Many honorable, worthy and able men of the profession have a horror of and shrink from attendance at our courts. For this courts are in a measure responsible. The self-respecting physician has no special relish for being badgered by an impudent lawyer.

An eminent jurist puts the matter in a strong light: "There is need of reform in our present method of giving expert testimony, which is rather calculated to embarrass than to aid courts in reaching a right conclusion, owing to the fact that experts are employed by the respective parties and almost invariably, though perhaps unconsciously, become partisans; and because they are accustomed to give unqualified opinions as to the mental condition of persons in answer to hypothetical questions which group together isolated acts of excentricity, incoherence or forgetfulnesss, whereas their answers should be qualified by the assumption that the facts supposed truly and faithfully represent the characteristic and conduct of the person suggested. For it was quite possible so to group his exceptional peculiarities of widely different periods, as to make the most sane of men appear to have been of unsound mind, whereas a right judgment required that the alleged peculiarities and exceptional conduct should be taken with his countervailing moral conduct and characteristics, and that their due significance should be assigned to each."

The respect which was once paid to the testimony of experts has diminished. Calvin, an eminent judge, says: "I think the opinions of experts are not so highly regarded now as they formerly were, for while they afford aid in determining facts, it often happens that experts can be found to testify to anything, however absurd." And yet another goes so far as to say: "If there is *any kind* of testimony that is not only of no value, but even worse than that, it is, in my judgment, that of medical experts. They may be able to state the diagnosis of a disease more learnedly, but upon the question whether it *had* at a given time reached such a stage that the subject of it was incapable of making a contract or was irresponsible for his acts, the opinion of his neighbors, of men of good common sense, would be worth more than that of all the experts in the country."

The profession will admit that there are grounds for the severity of these opinions. It is a fact that this kind of opinion is extremely unsatisfactory. The difficulty comes largely from the manner in which the witnesses are selected. While it is left to the parties to select their own expert witnesses, there will be two trained bands of expert witnesses against each other, since neither party is bound to produce, or will be likely to produce those as their witnesses who will not confirm their views. There are no theories so absurd that some unique philosopher may not be secured to testify that he believes it.

It would be somewhat embarrassing, if not a difficult question for a court to decide as to whether a witness offered as a medical expert was not a quack or speculative theorist and therefore inadmissable as an expert. Yet the trouble remains that very much of what passes under the misnomer of expert testimony is clumsy speculation. Under existing methods experts are open to the very serious objections, that they are unofficial persons selected by the party calling them because their pre-ascertained views will serve the party's necessities.

As a remedy for the present faulty and unsatisfactory method (as urged by one of our eminent judges) the courts should be impowered to appoint experts in the case,

to whom should be submitted the questions which should embrace a substantial statement of the facts as claimed to have been proven by the respective parties, and their answers taken upon the several assumptions. Then experts would not be subject to partisan "coaching," or tempted to assume the championship of either side of the case, but would stand indifferent, with nothing but their learning, their skill and their respect for truth to influence their opinion.

Such a method of expert examination would furnish the courts and the profession with a valuable collection of expert opinions on litigated questions, and certainly would add greatly to the weight of medical expert opinion.

It is a maxim of law that witnesses are not to be counted, but be weighed. It must be confessed that many of our medical experts are of light weight.

Where wealth or great interests are involved the temptation to almost any form of expert opinion can be made very strong. When required to give time and labor to the elucidation of questions on trial before our courts, the better opinion is that experts should be entitled to special fees.

# ABSTRACTS.

## THE CHOLERA IN CONSTANTINOPLE.

Prof. A. L. Long, of Roberts College, writes, (*Independent*):—For two years the reports from both Europe and Asia, in regard to the spread of cholera, had left but little hope that Constantinople, which had suffered so severely in former visitations, could escape. A rigorous system of quarantine was established and maintained during the whole season, and the gratifying result was that no authenticated case of cholera occurred in the city or its suburbs. This was considered a great victory by those sanitarians who advocate the quarantine system.

Again, in the spring of 1893, the season opened with cholera in both Europe and Asia, with increased mortality over the previous two years. By order of His Imperial Majesty the Sultan, the Sanitary Council proceeded at once to take measures for the defense of the capital. Quarantines were established by sea and by land. All arrivals from the Black Sea were quarantined at the entrance of the Bosporus, or else required to pass through under the yellow flag, and carrying a guard to see that no communication was made at any point with the shore. All arrivals from the Mediterranean were quarantined either at the Dardanelles or at Clazomene, near Smyrna. The land approaches were also well guarded. The through trains from Paris were stopped; and at the Turkish frontier there were erected huts, where all travelers were compelled, under strict surveillance, to pass a period of from five to ten days' detention, followed by fumigation and disinfecting processes of the most disgusting and often most indelicate kind. Remonstrance was of no avail. Serious injury was frequently caused to persons in delicate health by being almost suffocated in passing through the smoke box. Quarantine came to be more dreaded than the cholera itself.

The following incident will illustrate the strictness with which the quarantine regulations were carried out. An English steamer, passing down the Bosphorus, bearing the yellow quarantine flag, was run into by another vessel just opposite the village of Bebek and had a large hole punched in her side. With no little difficulty and danger she reached shallow water, and preparations had to be made for lightening her cargo and mending the great hole in her side. No one was allowed to leave the ship, although lying

within a stone's throw of land. The guard boat from the Quarantine Station soon arrived, and the cordon of soldiers in boats drawn around to prevent any communication with the shore. The workmen who came to repair the damage and the lightermen who came to take out a portion of the cargo all had to be considered as in quarantine. There was no case of sickness of any kind on board, only the vessel was under obligation to go through under the yellow flag; and even an accident was not to be allowed to relax the vigor of the law.

Notwithstanding these precautions, however, before the summer was fairly commenced there were some cases of sudden death in various parts of the city. The local newspapers at once received orders from the "Press Bureau" that no mention of the word *cholera* would be permitted, and no news of any sickness and death should be published, except such as would be officially communicated by the Sanitary Council. In all communications the term "suspected malady" was employed from a kind of superstitious dread of the word "cholera."

Suddenly, in the insane asylum—or, more properly, madhouse—in Scutari, some disease broke out which carried off more than eighty of the unfortunate inmates in one week. Probably the truth will never be known as to the cause of this outbreak. It may have been a case of poisoning from improper food. I have heard it asserted that a recently returned pilgrim from the holy places, having a relative among the insane patients of that establishment, obtained permission to visit him, and seized the opportunity of giving him some water from the Holy Spring which he had brought with him for that purpose. The miraculous water cured the patient and eighty or ninety of his companions by a speedy removal out of this world.

When it became evident that, whether cholera or not, some disease had made its appearance, the measures of precaution were increased. A specialist in bacteriology was summoned from Paris by imperial order, at a cost, it is said, of $20,000 and expenses; and he was asked first to determine whether this "suspected malady" was really the Asiatic cholera, and second to direct the measures to be taken for its extirpation.

After much talk, many meetings, examinations, microscopic and otherwise, fierce discussions, insinuations of charlatanism, accusations of imbecility, incompentency, mercenary motives, etc., it was decided that the disease was Asiatic cholera.

As the result of the deliberations of the council of experts, the whole city and suburbs were divided into sanitary subdistricts under the care of a special corps of doctors who were especially appointed for the work. Certain pharmacies were also named from which the necessary drugs were to be procured in case of need. The entire police force were also placed under the strictest orders to report immediately every case of illness of any kind whatsoever to these doctors, who were to be responsible for the entire treatment. All the pharmacies were ordered to report immediately every application for antidiarrheic medicines; and although the order was not actually issued, yet it was proposed to forbid employers giving their men any cholera medicines privately, lest cases might thereby fail of being reported and the work of disinfection be not attended to properly.

It was not very long before serious complaints began to be made by the people who were being terrorized over by the sanitary police, and were much more afraid of the police than of the disease. Very little, sometimes no attention was given to curing the disease; in fact, the patient was not expected to recover; but all efforts were directed to *disinfecting*. Stories were in circulation of most horrible treatment. A poor fellow was found lying in a corner drunk. The police came down upon him with their disinfecting apparatus. He protested that he was not sick, only drunk; but he was thoroughly saturated with carbolic acid, tumbled into a cart and covered with chlorid of lime and taken to the cemetery and buried, having been suffocated by the disinfectants.

Some of the scenes enacted upon the streets were worthy of the pencil of a Nast. A poor fellow is seen lying on the ground, not dead, but in a comatose state. A ring of soldiers is formed around him at a distance of a few yards, while behind them at a safe distance are standing two young doctors with eyeglasses, inspecting the case and noting down the facts in their note-books, and two sanitary servants

under their direction are lying down on the ground a ring of chlorid of lime around the patient as an effectual bar to any straggling microbes.

Many cases occurred where invalids not suffering from any like cholera were reported to the authorities, who, without investigation, sent soldiers to form a cordon round the house, and forcing their way in with their formidable apparatus, have frightened the patient to death, then burned up and destroyed the bedding and other clothing, and sent off the corpse to a hurried burial without the observance of any religious rites. This, of course, was not to be tolerated very long. The religious sense of the Moslem population was shocked and they found, at length, the means of reaching the ear of the Sultan, who was honestly trying to do everything in his power to avert the pestilence from his people. An official proclamation was accordingly made to the effect that all were to be permitted to call any physician of their choice, that any barbarities or extortion practiced by sanitary agents was to be reported for punishment, and that no burials were to be made without the consent of friends and every facility having been given for customary religious rites. This wise and humane proclamation from His Majesty had a very good effect in quieting the excited populace and securing a rational treatment of the epidemic.

The number of cases gradually diminished, until at length the specialist was dismissed and the most of the sanitary agents were also discharged. The enormous bills for chlorid of lime and carbolic acid, etc., were sent in and paid, and the public generally were breathing freely, and comforting themselves with the thought that the epidemic was finished. Within the past few weeks, however, the unwelcome guest has again made its appearance. Although the official reports give the number of cases as very small, it is rumored that the mortality among the military is serious, and that some seventy cases have occurred in the Imperial Guard. If this be true, it is very greatly to be feared that we shall have a severe visitation the coming spring and summer.

As to the question of the effectiveness of quarantine, the balance of evidence seems to be in favor of a rational and scientific quarantine.

As to disinfection, the great difficulty is to have it intelligently done. Processes which in veterinary practice have been found effective in stamping out the cattle plague are not admissible with human patients, but may result in a cowardly selfishness more deadly in its effects upon society than any pestilence.

## CASE OF LITHOPÆDIAN.

Dr. Oker Blom reports in *Duodecim*, a Finnish medical journal, a case of lithopædian, which was followed by normal pregnancy.

The patient was a women forty-two years of age, whose fourth pregnancy ended in pains for three days without any expulsion. After a time a tumor the size of a head could be felt in the abdomen. Three years later she again became pregnant, and in due course was delivered of a healthy male infant; the tumor, however, remained, and as the abdominal walls were very thin, its outline could be distinctly felt, the right hand with its fingers as well as the left hand being made out without any difficulty; the two forearms were flexed at right angles to the elbows and were fixed, but the humeri could be moved in the shoulder joints. The uterus presented the usual characters of the organ in multiparæ.—*The Lancet*, 1894.

THE magazines are cutting their prices in two and some of them are suspending. In these times of financial depression the only magazine that goes off with a boom is *the powder magazine.*

MANY people cannot be forced to believe anything that they do not wish to believe.

## OPERATIVE TREATMENT OF ENLARGED PROSTATE—LAMINECTOMY IN SPINAL INJURIES.

Before the Surgical Section of the Royal Academy of Medicine in Ireland, Mr. Arthur Chance read a paper on the Operative Treatment of Enlarged Prostate. He referred to a man aged fifty-six years, on whom he had operated by the supra-pubic method. Electrolysis had first been tried, but gave only temporary relief. The growth showed the "uniform circular enlargement surrounding the internal orifice of the urethra."

Prior to the operation the urine had been passed on an average every ten minutes; but now, more than ten months after the operation, the man could hold his urine with ease for ten or twelve hours. Mr. Chance considered that a catheter did not completely empty the bladder, and that, therefore, the usual method of estimating residual urine was open to fallacy. He advocated the use of a flushing gouge for the removal of the growth, for the reasons that it could be readily manipulated through a small incision, and also because of the value of a stream of hot water in stopping hemorrhage. He thought the supra-pubic drainage really meant overflow, and he, therefore, advised the insertion of a perineal tube as an addition to the supra-pubic operation. In conclusion he strongly urged the propriety of early operation.

Mr. Kendal Franks congratulated Mr. Chance on the success attending this case. He entirely agreed with him as to the value of supra-pubic drainage, but he thought that where they had a healthy perineum they should deal with it there, because it was putting the drainage in the most dependent position. Mr. Wyles thought the paper presented a subject of the greatest importance and difficulty. His own experience was that the diagnosis of these cases was not at all simple. Mr. Chance in reply to Mr. Franks said with regard to the closing of the bladder, that the probability of failure would be very much diminished if perineal drainage was employed, because there would then be no strain on the bladder. He admitted with Mr. Wyles that the difficulty of diagnosis was great, but he always adopted the precaution of first reducing inflammation by mild measures, and he thought that after that, the age and symptoms would lead them to a right conclusion.

Mr. T. Wyles then read notes of a case of laminectomy for spinal injuries, in which a man who had been admitted to the Richmond Hospital for paraplegia, the result of a fall from a cart on to the back of his head, had been operated on by him. The symptoms that were held to justify the operation were the presence of motor paralysis—complete in the case of the legs, incomplete in the arms—persistance of cutaneous sensibility, and the existence for twenty-four hours of reflex irritability in one lower limb. Mr. Wyles described the operation and the fatal termination of the case, and discussed the phenomena associated with these grave injuries, pointing out that it was only in fractures caused by direct violence that any reasonable hope of benefit by operation existed. Mr. F. A. Nixon, said that the operation was performed with great manipulative skill, and the cord on exposure seemed to him to be intact, and surrounded by its normal coverings. Mr. Doyle and Mr. Kendal Franks also spoke. Dr. J. Barton inquired as to the condition of the cord on making a post-mortem examination. Mr. Wyles, in reply to Dr. Barton, said, that no microscopic examination had been made, owing to the specimens having been mislaid. The cord had the appearance of being slightly bruised and flattened, but its continuity did not appear to be disturbed. He had hoped that the physiologists would be present, as he thought they might enlighten them regarding the process of evolution, which the physiology of the spinal cord was undergoing at present, judging from experiments on animals. It seemed to him that the clinical value of the spinal reflex was misunderstood.

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A WOMAN rather enjoys having you love her while conscious of her faults, because this is the triumph of her fascination over your reason; but a man cares little whether you like him or not, provided you acknowledge his superiority.—Manley H. Pike, in *Kate Field's Washington.*

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TELL nobody what you are going to do, keep silent while you are doing it and say nothing about it after it is done.

## MALIGNANT ENDOCARDITIS—THROMBOSIS OF THE PORTAL SYSTEM.

Mr. Burgess read a paper on a case of malignant endocarditis in a married woman, aged thirty years, who was six months pregnant. The chief interest lay in the obscurity of the case from the first, and likewise that it differed from the description of recorded cases in its symptoms. The prominent symptoms were pain of a lightning character, shooting in paroxysms from the inside of the knee to the base of the abdomen, and a fixed pain at the symphysis pubis; there was also, after a time, paralysis of the bladder. The temperature was 101° F., and a murmur was apparent from the first in the mitral valves, substituted in character.

Miscarriage took place on the seventh day, but as the sequelæ gave rise to no fresh symptoms, it was not regarded as a complication. On the 18th day embolism of the left cerebral artery occurred, followed by rapidly increasing coma and death on the 20th day.

The remarkable points were: 1. Murmur, which was present from the first, with an absence of any previous history of rheumatism. 2. The nervous phenomena, which were the distinct features. 3. The temperature, which was of the continuous type. 4. Its already alluded to difference from the ordinary forms of pyæmia-cerebral, cardiac or septic. 5. No occurrence of emboli took place until the 18th day, and there were no signs of renal or splenic embolism the whole time. 6. The peculiar absence of perspiration. The treatment was symptomatic. Dr. Tweedy and Dr. Moore commented on the difficulty that frequently existed in making an early diagnosis with accuracy. The president then related a case of thrombosis of the portal system in a man aged thirty years. He was anæmic, the legs were swollen, but there was no albumen in the urine, either then or subsequently. Some months later he was admitted into hospital for severe abdominal pain, which had developed thirteen days previously. He was very weak and sallow, and suffered from dry retching. The abdomen was distended and tender. It was dull at the lower part and sides, and fluctuation could be detected; there was no enlargement of the cutaneous veins. A systolic murmur was heard over the heart, at the base and apex. The bowels were loose and there was pyrexia. He became worse and died in collapse after a week's stay in hospital. Post mortem, the liver was found to be normal in size, very hard and tough, with nodular cirrhosis, especially on the under surface of the left lobe. The gall-bladder was flaccid. About two and a half quarts of thin serous fluid escaped from the peritoneum. The spleen was enlarged and firm. The portal vein was adherent to structures in the transverse fissure. It was much dilated, and its coats were thick (about three m. m.) and leathery—not calcified. Its interior was occupied by a firm, yellowish granular thrombus adherent at one side to the veins, but not completely obstructing its lumen. The branches of the portal vein through the liver were filled with soft thrombi, closely fitting, and yet capable of being withdrawn. The mesenteric veins were occluded by soft red thrombi. The jejunum for about one foot was adherent to the ascending colon by soft recent lymph. There was acute recent peritonitis over the liver and over this portion of the bowel, which was intensely congested and nearly black, resembling a strangulated intestine. There was no blood in its interior; the mucous membrane was eroded. The walls of the rest of the small intestine were much thickened by œdematous swelling. Several veins near the pyloric end of the stomach were firmly thrombosed. Pleural adhesions existed on each side, and there was effusion into the right pleural cavity. The probable order of events was: (1) Cirrhosis of the liver; (2) thrombosis of the portal vein; (3) sudden extension of the thromboses to the gastric and mesenteric veins; and (4) peritonitis.—*The Lancet*, 1894.

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VACCINATION threatens to become a universal panacea in the ingenious hands of Continental *savants*. Inoculation against snake bite is the latest production in this field, brought forward by Messrs. Phisalix and Bertrand at a recent meeting of the Academie des Sciences.

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NOTHING less than half a dozen daughters will keep some men straight.—*Dallas-Galveston News.*

# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*February 22nd, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### CASE OF MICROCEPHALUS.

J. L. HOWARD: This child is aged three and a half years, and presents a typical case of microcephalic condition; he does not notice anything, cannot walk, cannot talk and has epileptic convulsions nearly every day. He has had as many as two or three in a night. I simply brought the case in connection with one shown by Dr. Vance at the last meeting of this society. It might be well to state that the mother of this child had a fright at about the fourth month of pregnancy, an occupant of the house having had a convulsion in her presence.

### CASE OF EPILEPSY.

No. 2.—This girl is twelve years old; family history very good; she had never been sick with the exception of measles, in July, 1893, and her present trouble which is epilepsy. The first convulsion occurred when she was eight months old, and the seizures continued with considerable regularity for five years. She gradually grew worse; the convulsions coming on at shorter periods. For three years subsequently, that is after she was five years of age, she was free from any attacks and remained so until recently. They have come on again greatly increased in severity and she was put under treatment. She first came to me, and was afterward treated at the University Clinic. The treatment had been bromide of stramonium. The mental development seems to be more marked than we would expect. She has attended school this winter, and while she seems bright enough to look at, they have been able to do very little with her at school.

### DISCUSSION.

DR. A. M. VANCE: I think the microcephalic case exhibited by Dr. Howard belongs in the same category, as the one I showed two weeks ago. Case of microcephalic skull with spastic symptoms. I believe that the operation that is being done for this condition, as I said at the last meeting, is no longer warranted by experience and ought to be obsolete; that of craniectomy or craniotomy.

### OSSIFICATION OF THE CHOROID.

DR. WM. CHEATHAM: This specimen is an eye that I removed last week. I think it is the most perfect ossification that I have ever seen; the so-called ossification of the choroid. The degeneration extends as far forward as the choroid. While this condition is called ossification of the choroid, you will observe that the ossification is between the choroid and retina. There was no history of trauma in this case, and the trouble was referred to a rheumatic attack in early life. One strange thing about the case, is that in the family there are three men bearing identically the same name, each man has only one eye and that is the left eye.

### DISCUSSION.

DR. S. G. DABNEY: The specimen shown by Dr. Cheatham illustrates the dangers to which a good eye is exposed by the presence of a blind one, even after years of blindness. I exhibited several years ago to this Society an eye which had been lost also without any trauma; the eye had been blind for many years just as in the case reported by Dr. Cheatham. In this case the ossification did not extend far enough forward to be very well felt on palpation, so diagnosis was not made until after the eye was removed. The patient was a man and attention was attracted to his blind eye by its sensitiveness to pressure. There were also symptoms of sympathetic irritation in the other eye which disappeared on the removal of the offending eye.

### CONTINUED REPORT—FIBROMA OF THE URETHRA; OPERATION.

DR. T. S. BULLOCK: At a meeting of this Society some months ago, I read a paper on the subject of "Tumors of the Urethra" and exhibited a female patient having such a tumor. I operated upon the case one week ago last Wednesday, and present here for your examination the tumor removed. The only point of interest is, that in the former discussion of the subject there was a difference of opinion as to whether it was a fibroma of the urethra or of the space between the urethra and the ostium vagina. Some of us took the ground that there was no such space from an anatomical standpoint, and the removal of this growth clearly demonstrated that it was attached to the posterior semi-cir-

cumference of the urethra. It was very easily and quickly removed with an ordinary scalpel; there was little hemorrhage and no after effect whatever. The specimen is of interest from the fact that I believe none of the members at the time the case was exhibited had ever seen a fibroma in just this situation.

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FOREIGN BODY IN THE LUNG.

DR. D. T. SMITH: I merely wish to present for your examination this piece of metal, a gold collar button weighing about forty-five grains, which remained three years in the apex of the right lung of a little girl, causing some inconvenience, some pain, especially centering there when she caught cold, but without any other disturbance. Since she coughed it up she has recovered from that condition, and is entirely well.

The case illustrates the fact that foreign bodies may remain in the lungs for a long time with comparative safety. It has been commonly thought necessary to remove such objects at once by tracheotomy.

DISCUSSION

DR. J. A. LARRABEE: In regard to the specimen exhibited by Dr. Smith, and the innocuousness and harmlessness of such bodies, a much smaller specimen than this produced death indirectly in a case that I saw after three years. I performed a post-mortem and found a small rivet, such as is used in fastening the edges of stove pipes together, in the right lung. It had passed down into the right bronchus, thence entering the bifurcation of the lung. The child died of croupous pneumonia. The rivet acting as a foreign body I think played an important part in the cause.

I merely mention this case to emphasize the fact that these bodies are not so harmless as we might be led to infer from the very fortunate result in Dr. Smith's case. In the case I have incidentaly referred to, the patient who swallowed, or was supposed to have swallowed this rivet, remained three years under treatment for obscure lung trouble, and finally died. At the post mortem the cause of the trouble was ascertained. An interesting feature in the case was that the croupous membrane extended into the bronchial tubes of that side only.

DR. Cheatham has just called my attention to another case I saw some time ago, in which a shell of a peanut was accidentily drawn into one of the bronchi, resulting in death in five days. So that foreign bodies although they may be much less in size than the one shown by Dr. Smith—which is very interesting because of its being divided into two parts—may result seriously, and should not be regarded by any means as harmless. Dr. Smith's case is certainly exceptional, and I do not think we ought to expect to see so happy a result from such accidents.

DR. STONE, of Hopkinsville, (visiting); In regard to the innocuousness of the presence of foreign bodies in the lungs, I would like to mention one case, and hear the subject discussed at greater length. A child from near Hopkinsville was sent to Nashville, Tenn., to be operated upon about two weeks ago, and the doctors there removed a grain of corn from a point just at the bottom of the trachea. It had passed through the trachea down to the bifurcation of the bronchi. Would it have been proper to have left that child without operation for any length of time? Would there not have been some danger of suffocation? In other words was operation for removal of the grain of corn demanded, or could the child have recovered without it? I will state that since removal of the foreign body, the child has made a very happy recovery.

DR. WM. CHEATHAM: In reply to Dr. Stone—several cases of the character he mentions—six or eight, at least—have occurred in Louisville within the last few months, where tracheotomy has been performed for the removal of foreign bodies from the trachea. I think all of them should be removed through the trachea at once, and especially grain of any kind which is so liable to increase in size by swelling as it becomes moistened.

DR. A. M. CARTLEDGE: I think Dr. Smith is entirely too modest in requesting that his case be not discussed. My own experience to a certain extent bears out the assertion of Dr. Larrabee in regard to leaving some of these cases alone. I have had three cases of foreign body in the trachea; in one the foreign body, a piece of corn stalk, was expelled after four or five months; I did a tracheotomy and kept the wound open for eleven days, but the foreign body did not come up, but was eventually expelled. In another case the foreign body was a tack; a tracheotomy was performed, but the tack was never found. A tracheotomy in the third case was done and a grain of corn was readily removed. The statistics, as Dr. Cheatham suggests, do not bear out the harmless character of foreign bodies in the trachea. No matter what the character of the foreign body is, the proper thing is to do a tracheotomy, and if not found at once to keep the wound open a reasonable length of time in the hope that it may be expelled. It seems to me very remarkable that the foreign body in Dr. Smith's case passed up through the vocal cords. The probabilities are that an abscess formed, which eventually broke and the piece of metal was expelled in that way.

Dr. Wm. Bailey: One point of interest occurs to my mind from the discussion by Dr. Larrabee, that is the possibility of foreign bodies producing or creating *croupous pneumonia.* Whether it is possible for either trauma or the irritation of a foreign body in the air passages to produce or cause *croupous pneumonia* which is perhaps a *specific disease,* it occurs to me would be a very difficult question to decide.

Dr. J. A. Larrabee: In speaking of *croupous pneumonia* I should have said the production of *croupal membrane* in the air passages. I believe that the irritation of the foreign body in the bronchus was an important factor in producing croupal membrane in the air passages, but of course it did not directly produce *croupous pneumonia.*

Dr. Wm. Cheatham: Dr. Vance and myself had a case some years ago in which a man was eating what his wife called "Noodle Soup" and accidently, a piece of bone as large the end of my thumb, was taken into the throat passed into the larynx and thence into the left bronchus. We performed a tracheotomy, and kept the wound open several days but the foreign body was not expelled. Dr. Krim six months afterward exhibited the piece of bone to one of the Societies, it having been coughed up even after the lung had become gangrenous. The left lung was found to be perfectly gangrenous, yet the man had forced this foreign body up through the larynx six months after it had been taken in.

Dr. D. T. Smith: I did not mean to say the presence of foreign body in the lnngs should be regarded as harmless, but the popular notion is or has been, that if a foreign body gets into the lung, if it is not immediately removed the result will necessarily be fatal. There is a very general impression among the people that such an accident is fatal in its results. Tracheotomy is by no means a dangerous operation, and in all cases where the foreign body is a bone or grain of any kind which is likely to swell or decay I believe the proper thing to do is to make an effort to remove it. I remember a case where a piece of ginger remained in the throat of a boy (he was a man when it was coughed up) for thirteen years. He was a man in fair health when I knew him, which was after the foreign body had been expelled; his lungs had remained weak and he was subject to occasional hemorrhages from the spot where the ginger had been lodged.

I happened a few days ago, since I received this specimen, to be looking over a German journal and noticed a list of quite a number of cases similar to this which had recovered without operation. One of them, strange to say, where a set of false teeth had passed over the epiglottis during sleep and had lodged in the vocal cords, and remained there for several months unsuspected. This was afterward removed and the person recovered. Of course it did not reach the lungs. When the foreign body consists of pieces of gold, silver or something that will not decay, I think the danger is very much less than is popularly and generally supposed even by the medical profession. I merely make these statements as a source of hope to those who may have foreign bodies in their lungs, that the result is not so dangerous from their being left there as is commonly supposed.

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The essay of the evening was by Dr. J. A. Larrabee, on the subject.

EPILEPSY

(See page 447.)

DISCUSSION.

Dr. J. B. Marvin: All of Dr. Larrabee's papers are interesting, and the one we have just listened to is no exception. There are one or two points that I would like to mention. He tells us of the number of cases he has had where cures have been effected; he does not tell us the number of cases treated during the same length of time which were not cured. The number that he has cured, if I understood him correctly, by methods not generally recognized as being most beneficial in therapeutics, struck me with some degree of force. The history of epilepsy is so well known, as he indicates, and the therapeutics are so extensive, and the profession as a whole have had such bad results with these metal salts, that when the bromides were introduced the effects were so much better that the majority of the profession rather looked upon bromides as specifics. Reaction has come on, the pendulum is swinging the other way, we now know that the bromides are not specifics. Certainly the statement that ninety per cent. of certain cases of epilepsy are amenable to large doses of silver salts—to the point of toxicity—long continued, is startling. I think this statement will be borne out by statistics if we can rely upon them, that a greater percentage of cases of epilepsy are benefited by the administration of bromides than any other single or combined remedy. Another thing, I think in those cases where we do not get the marked acne from bromides, the treatment shows better results than the converse. I believe also that this statement will be borne out—that there is a way of giving the bromides without producing all of the ugly and detrimental effects as pictured by some authorities, so that it is perfectly possible to give the patient bromides to the point of tolerance without producing mental hebitude, cachexia

and gastric and cardiac depression. This subject to my mind has about resolved itself at present into two classes: One class who look upon epilepsy from a medical standpoint and who continue to drug it. That class can be sub-divided into the surgeons who operate for the traumatic cases. There is a tendency now in the other class to do away with medical treatment, bromides and every other form of treatment, and claim that all of these so-called phenomena of epilepsy are due to peripheral irritation, and a great many operations have been performed, especially about the eye for correction of so-called muscular strain, and they claim to get better results than by any internal medication. Taking this view of the situation, if epilepsy is produced by long continued peripheral irritation, is it not more rational to remove that peripheral irritation by some operative procedure rather than to give some internal medication to attack the cerebral centres which is almost certain to keep up the peripheral irritation?

I have long since come to this conclusion, that if I had to choose between the bromides, or any other form of medication, and simple regulation of diet and the bowels, I would take the latter in preference to the former. There is certainly no question in my mind but many cases are dependent upon gastric indigestion, retained fecal matter, toxæmia, or whatever you may choose to call it, and by getting that part of the system in an aseptic and healthy condition, we can sometimes accomplish more good than by keeping the patient thoroughly under the influence of the bromides. There is another point just there that I cannot settle, bearing on the latter subdivision that I mentioned, which is agitating the profession at the present time; namely that of operations upon the eye and other organs whichever might be supposed to be the exciting reflex cause. It is a fact as we all know that the nervous system especially tends to perpetuate certain actions; a spasm occurs to-day or maybe two; it comes on more easily to-morrow, the next day still easier, and so on. If you will take a frog, get him to remain quiet and stroke his back gently, he will manifest signs of pleasure. You may excite his sexual desires and he will exhibit all the manifestations of pleasurable sensation. If you will take that frog and remove his cerebrum he will still live, and after he has recovered from the primary shock you can still by the same stroking of the back excite exactly the same motions. Now that is the important point: If it is so, and it certainly is, there must be two factors in the production of epilepsy. Certainly after the first attack, whether from peripheral irritation of the eye, stomach, penis or any other organ, there is that condition of the brain which renders the subject more susceptible to ordinary peripheral irritation. Now the practical point is if that is so will we get good results in cases of long duration by simply correcting the peripheral irritation? Will the habit not already have been formed, and the tendency be to keep it up? It is questionable in my mind whether epilepsy is curable by tenotomies, prisms, etc. about the eye.

Bromides may be given for a long time without any bad effects, and I think the majority of authorities differ in regard to the best salt. The ammonium salt is perhaps a little more stimulating and rather less depressing, but I think the best results are obtained from the bromide of potash.

I have had some cases under observation for four years without any return of epilepsy; in other cases the attacks have returned after a few months.

DR. D. T. SMITH: A more interesting subject could hardly be introduced for discussion than epilepsy, and I am sure not a more profitable one could have been selected. My experience, which has not been so great as that of Dr. Larrabee, has been all under authority; I have never departed from the ordinary routine treatment, therefore can say but very little except what has been gained from the experience of others. As Dr. Larrabee says the disease has been present in the human family from time immemorial, it is recorded by the earliest writers, and for years it was regarded as being a production of devils. This was generally believed, and in order to treat it successfully it was necessary for the operator to be able to practice the extirpation of these devils. Josephus claimed, if you will remember, a man in his time who practiced this by drawing them through the nose of the patient; that this could be seen by the natural eye, and as evidence that this man could draw the Devil through the nose of the patient, the epilepsy was cured. Of course the result was entirely due to some mental effect produced upon the patient, and as he believed that the Devil had actually been drawn through his nose, or the cause of his epilepsy if you please, the result was that he was entirely relieved.

In regard to the pathological condition, the causation of epilepsy: Many writers claim that it is a vaso-motor spasm. I think if anything has been disproved it is the contention that epilepsy is due to vaso-motor spasm. I think it is settled with reasonable certainty, that as far as we know, and we can go no further, that the cells have an accidental or premature discharge of force, and this is the active factor in the production of an epileptic attack.

In regard to peripheral influences: I took occasion in the last paper I read before this

Society to deny, on the authority of Dr. Landon Carter Gray, any relation between the production of neuroses and the production of epilepsy. Gowers as well as Gray also states that the cases are exceedingly rare where peripheral influences have anything to do with the causation of epilepsy. One case was reported where a scar on the finger was believed to be the cause of the epilepsy; and in which the amputation of the finger cured the epilepsy. Other similar cases are reported, but the general opinion of neurologists is that a neurosis is present and that growths, scars, or peripheral irritation act merely as the exicting agents. If it could be demonstrated that the exciting cause of a case of epilepsy was a spicula of bone, then it would seem reasonable that its removal might effect a cure; on the other hand some change might have been brought about in the neighboring nerve cells which would cause a continuance of the seizures even after the offending substance had been removed.

Referring to Dr. Larrabee's statement as to the avoidance of meat in epileptics: That meat food acts as a preventive of epileptic attacks has been demonstrated beyond peradventure in a certain proportion of cases. Gowers especially recommends that meat be given in such cases.

DR. T. H. STUCKY: I would like to ask Dr. Larrabee if he has ever used the bromide of gold and arsenic in the treatment of epilepsy. At the last meeting of the Mississippi Valley Medical Association, I listened to a very interesting paper read by Dr. Wood, of Pittsburg, Penn., who presented me with a two ounce sample bottle of this preparation made by Hayes after the formula of Dr. Barclay. At that time I happened to have a little girl under treatment for epilepsy, who was having from three to five attacks per month. I took her to the clinic that day and she was placed upon five drops of the bromide of gold and arsenic, gradually increasing the dose until the effects of the arsenic began to show itself in puffiness of the eyelids, etc., then the quantity was again reduced to five drops. She has been kept upon this dose without any return of the epileptic attacks. Whether the result is due to the curative effect of the bromide of gold or the combination I am not prepared to say. I am inclined to believe the latter.

I have had one case under observation since 1886, nearly eight years, under the constant use of bromide not carrying it to bromism but to the point of tolerance for a period of nearly two years, and there has been no return of the epilepsy up to this time.

DR. H. A. COTTELL: Epilepsy is a thoroughly worn out and threadbare subject, and I doubt very much if there is anything new to offer upon it. When I took charge of the clinic at the University two years ago, a great number of epileptics presented themselves, old and young, and almost every known remedy for this affection was tried there. About this time bromide of stramonium came into notice and was attracting considerable attention, and I gave this remedy a thorough trial at the clinic. The results were seemingly satisfactory. But this is the old bromide treatment over again. The only argument that can be made in favor of bromide of stramonium over bromide of potassium and sodium is that the stramonium salt has a molecule which carries two atoms of bromine, while the others have a molecule which carries only one. Thus the potassium salt is K Br1, while the stramonium salt is SrBr2. A point in in favor of bromide of stramonium is that we can get the patient a little more rapidly under the influence of bromine with it than with the other remedies. I do not believe that there is any remedy for epilepsy. Even nitrate of silver will not cure it, though I am quite sure its continued use will make the patient resemble the polished stove pipe so pertinently described by the essayist.

I have never cured a single case of epilepsy.

DR. D. W. YENDELL: Concerning the pathology of epilepsy: The essayist spoke of how little we knew about it, which I readily admit to be the fact. In all my experience I have only made three *post mortem* examinations for epilepsy. One was when I was connected with the Medical Staff of the City Hospital, on a confirmed epileptic who had been made blue by nitrate of silver. It was before the days of bromides. Bromides did not come into use until Locock brought them prominently before the profession in 1862. In one case where I made a *post mortem* the membranes of the brain were found to be studded with hydatid cysts; there could not have been less than fifty or sixty of them scattered throughout the brain, varying in size from a shot to a hazelnut. Another case was one of traumatic epilepsy, where a man had been stabbed with a pocket knife. There was a little scar, when he came into the Hospital, just at the inner canthus of the eye. The knife blade had been broken off smooth with the soft parts; it had suppurated and a scab had formed over the wound. Of course it had not wholly cicatrized, and there was still a small open wound covered by a scab. The man died in an epileptic convulsion, and in taking off the calvarium, just inside and above the eye there was a considerable abscess filled with pus, and containing the piece of knife blade. The knife remained there in the man's head for over a month, causing repeated epileptic convulsions and finally death. These

are the only two contributions to the pathology of epilepsy I have to offer. The third *post mortem* was in the person of a child, where nothing out of the usual order of things was found.

In reference to the treatment of epilepsy; I have had no experience with the use of the metals Dr. Larrabee has spoken of. There are two great factors in the therapeutic management of this affection; first, attention to the diet; next, the use of the bromides to the full point of tolerance. I think I can say with perfect truth that I have seen a great many cases of epilepsy both in children and in adults entirely cured. I think anyone can fairly be called cured who goes without a seizures for a period of five years. I know a number of cases that have gone without any species of seizure whatever for five years, and several who have gone for ten, fifteen or twenty years without any recurrence whatever of a seizure.

I do not see any material difference in the relative value of the several bromides as between ammonia, potash or soda, sometimes I use one sometimes another. But before giving the bromides in any form I ascertain the sensibility of the fauces, and throughout all the time I am giving them, I frequently test the sensibility of the fauces—my object being to fetch about anæsthesia of the fauces in a short time, in a word to bring about complete anæsthesia of the fauces, so complete that, indeed, the finger can be passed all round the palate and tonsils without producing gagging; when the individual does not gag we may then be pretty sure that he is sufficiently under the influence of the bromides, and we should endeavor to keep him just at that point. I think this is a very important point in the administration of the bromides. I usually follow a suggestion made many years ago by Trousseau. I combine atropia—he used belladonna, along with the bromides. Where I do this I push the atropia to its full effect, and generally give it as long as I use the bromides.

DR. WM. BAILEY: I want to be recorded as believing, and my firm conviction is, that in the bromides we have more control over epilepsy than by all other means combined. I think these cases ought to be kept on bromides properly diluted. Twenty to thirty grains, three times per day, is usually sufficient to control convulsions, and this treatment should be kept up for at least two or three years. I have had such good result from the use of bromides in the treatment of epilepsy that I rarely give anything else. I think in favor of the fact that there is a vaso-motor spasm, there is one remedy which administered just at the time of the aura will sometimes arrest the paroxysm, and that is nitrite of amyl. I simply offer this as an argument in favor of vaso-motor spasm.

DR. WM. CHEATHAM: Referring especially to Dr. Marvin's remarks in regard to epilepsy dependent upon peripheral irritation: Section of the eye muscles has not resulted in the benefit that was promised by the originator of the operation (Stevens). Several cases were submitted to him by (I think) the Ophthalmological Society, of New York, and he was given three years in which to cure them, by tenotomy, etc. It is useless to say that he failed in the majority of cases, so that tenotomy of the eye muscles has not resulted in the good promised.

DR. STONE: I know of several children that have been entirely relieved from epilepsy and there is no question but quite a number of cases occuring in children are *cured.* I also know of several men who have gone four years to my knowledge at the Asylum without an attack, who were not only epileptic but maniacal. I also know of one such result occurring in a female adult outside of the Asylum. This length of time seems to me sufficient to be called a cure.

The pathological evidences often show plainly that it is impossible for us to cure all cases of epilepsy even though they are not traumatic. For instance an autopsy made at the Asylum showed a spicula of bone growing down into the brain, an exostosis about three-quarters of an inch in length, from the inner surface of the cranium. In another autopsy at the Asylum ossification of one of the arteries centrally located was shown to be the cause of the epilepsy. In neither of these cases could the real cause have been ascertained during life, and we could not have expected to relieve the trouble by any manner of treatment or medication.

At the Asylum we use the bromides exclusively, preferring them to anything else; although I have used other remedies, it has been to a very limited extent. Our results in the management of most cases of epilepsy have been unsatisfactory, merely ameliorative.

DR. P. F. BARBOUR, (Visiting): I am sorry to say that I have not had such favorable experience with the treatment of epilepsy as to warrant my hoping very much for it. My experience has been mostly in Asylum life. Under the largest doses of bromide of potash we were unable to do anything with them. It seems to me that the only cases for which there is any hope are such as are found to be dependent upon peripheral irritation. If we can remove the source of irritation whatever it may be, we can look for some benefit.

I was struck with the remarks of Dr. Larrabee concerning the effect which a change of physicians was likely to produce in patients suffering from epilepsy. Really the only ra-

tional treatment we have for the epileptic is to do something that will divert his mind and thus inhibit the action of the reflexes.

I think this is why benefit is derived when a new physician takes charge of the case; it is something new for the patient to think about; it is the impression made upon him by a new physician and a new form of treatment that produces the good results. If a doctor has been treating his patient with bromides and changes to something else, the patient for a time will do wonderfully well under the new treatment. It is through the inhibitory action upon the brain fibres that the bromides secure good results. It seems to me on chemical grounds that bromide of sodium is the bromide we should use. Sodium is one of the normal constituents of the body, and can be given for a long time without producing any of the disagreeable effects that sometimes follow the administration of bromide of potassium or ammonium.

I have never given nitrite of amyl as suggested by Dr. Bailey at the beginning of an attack, but its use is indicated if we are able to see the patient just at the proper time.

DR. J. A. LARRABEE: Perhaps some explanation is necessary as to the number of cases that have fallen under my observation. I reported them as cures, some of them extending over a period of eighteen years. All the cases have been carefully followed, with the exception of the one in California, and I heard from him only a year ago, bringing that down to within a year's time with no recurrence of the epileptic seizures. I am far from claiming a cure in one year or two years time, but if a man or child has epilepsy, three, four or five attacks in a month, and then after treatment goes five years without recurrence of the trouble, I think it is entitled to be regarded as a cure, whether the patient may again develop epilepsy or otherwise. Of course, I recognize the truth of Hippocrates' statement which has so often been verified, that this disease is curable in the young but not in the old. Most of my cases have been in the young, which is a point I wish to emphasize.

Dr. Marvin has probably illustrated this subject better than any one else, and has touched upon a favorite idea of mine in speaking about the perpetuation of epilepsy by the impression made upon the nervous system, rather by the photographic process upon the brain, and I wish to thank him for the elucidation.

Several of the cases treated by me with the metal salts had been under treatment by the bromides and various other remedies without benefit. There is nothing particularly new in the treatment I have mentioned. As stated in my paper I believe the good results from the metal treatment are derived from storage in connection with the nerve cells in the discharging areas of the brain.

I have never had any experience in the use of bromide of gold and arsenic mentioned by Dr. Stucky. My report contains or includes a large number of cases and a very large and varied experience, Some one has asked the question as to how many patients treated in the meantime and not cured: A great many cases, perhaps five or six, have passed out of my recollection entirely, ceasing treatment while they were having spells. I do not know what has become of them.

With special reference to the dietetic treatment: One of the cases reported by me illustrates very clearly the effect of diet upon epilepsy.

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**From the Diary of a Quack.**

Kase 230, Mary An Perkins. Bisnes, wash-woman. Sickness in her bed. Fisik, some blue pils, a soaperifik; aged 52. Ped me one dollar, 1 kuarter bogus. Mind get good kuarter and mak her tek mo fisik.

Kase 231, Tummes. Krinks Bisnes, N Irishman. Lives with Pady molonny whot keeps a dray—Sikness digg in ribs and two blak eys. Fisik, to drink my mixter twice a day of sasiperily, bere and jellop, and fish ile, with asifedity to make it taste fisiky. Rubbed his face with Centaur Liniment. Aged 39 years of age. Drinked the mixter and wouldn't pay me bekase it tasted nasty, but the mixter'll work his innards, I reckon.

Kase 232, old Misses Boggs. Ain't got no bisnes, but plenty of money. Siknes all a humbug. Guv her sum of my celebrated "Dipseflorikon," which she sed drank like cold tea—which it was too. Must put sumthink in it to make her feel sik and bad. The Old Wommen has got the roks."

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THE value of vaccination is now fortunately forced into universal recognition abroad by the striking statistics showing the marked difference in fatality between those European nations which make it optional and those which do not. Recent official recognition at home includes the summary action of the Boards of Health in Illinois and Wisconsin, where all school teachers and pupils must be vaccinated, failing which school privileges will be denied them; while in Iowa compulsory observance of Jenner's discovery is enjoined on every person.—*The Outlook.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

AMERICAN JOURNAL OF OBSTETRICS

for March contains a paper by Dr. Grace Peckham-Murray on the

**Mechanism and Treatment of Procidentia Uteri.**

The author presents the following summary of her views:

I. The pelvic floor has little to do in causing complete procidentia. The proofs of this are: 1. It occurs in children, in young women, without so much as destroying the hymen. 2. It is rarely if ever seen in cases of complete laceration of the perineum.

II. The vagina may have both an active and a passive action in the mechanism of descent. If the band of levator ani muscles which surrounds its tube in the lower third is lacerated, and its lower portion is still held by the rectum, the muscles surrounding it act with a powerful traction to bring down the posterior wall of the rectum; this traction, with traction of a like nature on the part of the bladder causes a prolapse of the vagina alone if confined to the lower portion, but when it involves the upper portion there is dragging of the neck of the uterus, which if the uterine supports are not lax, results in the great hypertrophy and lengthening of the neck which simulates complete procidentia. If the uterine ligaments are relaxed the uterus will follow sooner or later. 2. The softening and relaxing of the connective tissue during pregnancy make the detachment of the utero- and vagino-vesical attachments an easy matter, rendering and predisposing to prolapse. 3. The uterus can press down the vagina before it, making the vagina a passive agent in cases of rapid labor when the os is not dilated and the uterus descends towards the vulva with expulsive force of the third stage; also when it is heavy from lack of involution, as when the patient gets up too soon after confinement, or when subinvolution does not take place. 4. The vagina affords support to the uterus by its attachments to its neck; but it is a question whether it acts as a supporting column in the mechanical sense expressed by some writers, and whether the angle it forms with the uterus has a supporting value. Clinical experience shows many cases in which the walls of the vagina bulge and are prolapsed, in which the uterus retains its position, and also many cases, notably cases of congenital retro-displacements, in which the uterus remains at its normal plane.

III. The action of the ligaments is more passive than active. They are naturally lax owing to the necessity of uterine movements and uterine growth in pregnancy. If traction occurs from below, and the ligaments are lax, descent of the uterus is more facile. 2. The importance of the utero-sacral ligaments is exaggerated by most writers. 3. The appearance of the ligaments in cases of prolapse does not show their action; the stretching, breaking, and elongating is the result of the displacement, not the cause. In this respect experiments on the cadaver may be trusted for displacements of the uterus on the normal plane, but not in descent.

IV. The greatest factor to be considered in uterine displacements, and the least understood, is the intra-abdominal pressure. In the normal state there is such an adjustment of this that the uterus is easily maintained in position with little aid from ligaments, vagina, or perineum, in spite of the weight of abdominal viscera or the great and constantly recurring force of expulsive effort. When this equation is disturbed descent becomes easy. The maintainence of the uterus in its normal position is more a matter of physicodynamics than is generally supposed.

V. Owing to laxity of tissues, inherited or the result of disease or subinvolution, there may be a greater predisposition to procidentia uteri. The loss of fat has nothing to do with it, cases occurring very frequently in women with great accumulations of abdominal and other fat. The shape and inclination of the pelvis may also favor this condition Some writers think that too much is attributed to the effects of pregnancy as an etiological factor. Owing to its relaxing effects on all the ligaments and connective tissues, the heavy uterus of subinvolution, and insufficient care, it can, in the author's opinion, be held responsible for ninety per cent. of the cases.

The paper, which is illustrated with many cuts, most of them taken from the standard works on the subject, will be continued in the next issue of the journal.

Dr. W. L. Burrage discusses

**The Electrical Treatment of Fibroid Tumors of the Uterus,**

giving the results of three years' use of this agent. During this time he has seen in hospital and private practice ninety-eight cases of fibroid tumor of the uterus. Forty-four of these were treated with electricity and received at least six treatments each. As the result of this experience he gives the following:

1. Hysterectomy is contra-indicated in a majority of cases of fibroids because of the high rate of mortality, and because it unsexes the patient—the latter, an important consideration in younger women.

2. Intra-uterine galvanism is most advisable.

3. We must not look for a permanent reduction in the size of the tumor.

4. Galvanism—vaginal, intra-uterine, or by puncture—does not cause abscesses or adhesions.

5. Galvanism is of no use as a means of diagnosing the presence of pus.

6. Treatment by electricity after the Apostoli method is absolutely safe.

8. Every case of fibroid tumor of the uterus should be under competent medical observa-

tion, because of the danger of malignant degeneration, kidney disease from pressure on the ureters, complications during pregnancy, and the liability of the occurrence of pain and hemorrhage, and functional nervous disorders, especially during a delayed and protracted menopause.

The author includes in his paper a table of the cases treated showing the result of treatment, the length of time under treatment and the number of applications of electricity.

Dr. C. S. Hoffman describes

**A Peculiar Monstrosity.**

The abnormalities of the child, beginning from above down, consisted, 1st, in its being hydrocephalic. 2nd. The left external ear was very rudimentary, while the right external ear was normal. 3d. The left eye was very small and the opening in the orbicular muscle was only about one-third that of the right eye, which appeared normal. 4th. Both arms termininated at the lower end of the humerus, the radius and ulna being absent; but where these two bones should join the humerus, forming the elbow joint, is joined an imperfect hand having only three fingers on each hand, these fingers resembling most the little, ring and fore fingers. 5th. The child is a bilateral hermaphrodite, having a testicle upon each side in closed sac. The penis is very rudimentary and looks much like an enlarged clitoris; just back of it is an opening as large as a small crow's quill, into which a probe can be passed one-third of an inch. 6th. The anus is imperforate, the continuity of the skin being unbroken. 7th. There is talipes calcaneus of the left foot. In other respects the child was well developed. The child was born dead, but the mother said she felt it alive shortly before birth. There is no reason for the arrested development of the child.

Dr. Hannah T. Croasdale, reports a case of

**Two Separate And Distinct Uteri,**

which were centrally situated and not connected. The patient, æt. 63 years and the mother of three children, was admitted to the Woman's Hospital, in Philadelphia, for treatment of an abdominal tumor. Twenty years before she had noticed some enlargement of the abdomen, and in five years it had reached, she thought, its present size. No discomfort was felt (except from the size) until recently, when she experienced pain and pressure symptoms, and the bladder and rectum became very irritable. The menopause occurred at 50, and at this time the woman was confined to bed for several weeks; but there was no special reason for this, or she forgot just why she was in bed for that length of time. At the section for the removal of the tumor, a small, nodular mass attached to the lower part of the tumor, having the size and shape of the uterus, and being furnished with what seemed to be the uterine appendages, was drawn out of the lower end of the wound, and was found to be attached by a small cord-like pedicle to the pelvic brim a little below the crest of the left ilium. Another body, to all appearances a uterus with its appendages, was found crowded down into Douglas' pouch by the tumor. The patient died of sepsis on the ninth day. At the autopsy a uterus and its appendages were found in the proper position. The author thinks it a case of two separate and distinct uteri. The second uterus had developed from the cervix the fibroma and measured from the internal os to the fundus one and one-quarter inches. On cutting it open the arbor vitæ arrangement of the mucous membrane was shown quite distinctly. The os uterinum on the left side admits of the passage of a small probe, which passes a short distance along the Fallopian tube. On the opposite side the opening would not admit the probe. There are two small ovaries. In the cervical canal, just below the os internum, is a small calcareous deposit.

The same author also reports a calcified corpus luteum.

Dr. W. P. Carr contributes a paper on

**Chronic Salpingitis,**

reporting five cases. The author does not advocate the removal of the appendages for every case of catarrhal or chronic salpingitis. He is certain, however, that adherent tubes or tubes containing small quantities of pus, may be the cause of suffering sufficient to wreck a woman's health without giving rise to any well-marked physical signs of pelvic disease. And when the pain is great, when the general health is being undermined, when other treatment fails, he thinks removal of the appendages becomes not only justifiable, but a procedure that it is the physician's duty to recommend. He believes, too, that in all obstinate and unyielding cases the tubes will be found to be solid cords in some part of their extent, and the woman will in consequence be always sterile, so that all arguments based upon the sterilization and mutilation of women are inapplicable to these cases.

The remaining papers in this issue are:

"Acute Non-Puerperal Metritis, with report of a case," by Frank H. Murdock, M. D.

"The Complications of the Puerperal State," by Llewellyn Eliot, A. M., M. D.

"The Causes of Shoulder Presentations, With a Report of a Case," by Sigmar Stark, M. D.

"Three Illustrative Cases of Abdominal Section," by Aug. Schachner, M. D., Ph. G.

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ATLANTA MEDICAL AND SURGICAL JOURNAL for March. Dr. A. Joffray, of Paris, writes of the

**Nature and Symptoms of Exophthalmic Goitre,**

and thinks that it is due more to some functional vice, or to some alterations in the thyroid gland, than that it is a pure neurosis.

The four principal signs usually given are the exophthalmia, tumor of the thyroid, rapid pulse, tremulousness of the extended hands. The right lobe is generally found larger than the left, and on applying the hands to the organ pulsation and also a characteristic thrill are felt.

Contrary to the common teaching, the author says, there is no such thing as a purely vascular enlargement of the thyroid; but we can always find, by careful examination, hard nodules of circumscribed inflammation or of colloid infiltration, showing an organic change, and this is the case in those which appear to be of only a few hours' duration as well as in those of more gradual appearance. In some cases even, when the other symptoms were marked, inspection, or even very careful palpation failed to disclose any enlargement in a thyroid which at a subsequent autopsy showed very great hypertrophy.

At menstrual periods a goitre is apt to enlarge, under the influence of various emotions it may do so, and may diminish without relief of symptoms; or the symptoms may lessen or disappear without apparent lessening of the goitre.

The heart usually beats strongly, slowly, and regularly; but in a longstanding or cachectic case, without organic heart affection, there may be irregularity or intermission of the beat. In some cases organic change occurs in the heart apparently as a result, at other times it seems a mere coincidence.

The carotids and other cervical and cephalic vessels often dilate and throb greatly, while, in contrast, other arteries may be almost imperceptible.

Exophthalmia is common but not constant, and when present is usually unequal but bilateral, the degree bearing no apparent relation to the development of the disease, and there is also no relation between the eye most affected and the greater lobe of the goitre.

In spite of displacement the author says there is often no visual disturbance, but the various muscles around the orbit are interfered with, and to this is due the sign of De Graefe (the failure of the eye and upper lid to move in unison) and that of Stellwag (the enlargement of the palpebral fissure, and the failure to completely close it, although the sensation of having done so exists.)

This symptom of Stellwag appears without perceptible exophthalmia and may be almost wanting in pronounced cases.

Paralysis of the muscles of the forehead and face occurs and is apt to be symmetrical, and a vibratory motion of the eyelids, simular to that seen in hysteria, the author calls "batting," and states that although all of these are important phenomena they have not received due attention.

Dr. N. F. Howard "Gives a new Treatment for Burns." A solution of one pound Epsom salts in two quarts of water, in which the burned part is to be immersed if possible. This treatment gave prompt relief in a couple of cases, where the ordinary treatment of linseed oil and lime wates had failed.

After relief of pain the usual dressing was applied, and healing rapidly took place.

Dr. W. P. Northrup read before the New York Academy a paper on

**Scurvy in Children,**

and in the discussion it appeared that members had observed seventy-two cases, and since attention has been attracted to the subect lately only, it must be of rather frequent occurrence.

The author mentioned a few individual cases: The first was a foundling brought to the hospital with swollen leg and knee, and developed swollen and spongy gums, and hemorrhages into the skin and bowels. At the autopsy pleuro-pneumonia, and entensive femoral and tibial subperiosteal hemorrhages were found.

Another child, the parents being people in good circumstances, had been fed on prepared baby food for a year, when much the same condition developed. Rheumatic treatment failing, the child was fed on milk, beef-juice, potatoes and orange juice, and promptly began to improve.

Much the same features prevailed in other cases; one had been fed by a wetnurse, who at the same time nursed her own child; but most of the infants had been fed on patent baby food or condensed milk, one on beef juice for three months.

Various diagnosis were given by the physicians who first saw the cases—hip disease, spine disease, infantile paralysis, etc., and in one case cited the spinal distortion seemed quite evident, but turned out later to be due to contractures of the muscles from effusions into their sheaths and to periostitis.

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BULLETIN DE THERAPEUTICS

Dr. Darrier describes a treatment of

**Epithelioma of the Face**

with which he claims success.

After removal of scales and crusts, the surface is anæsthetized with ten per cent. solution of cocaine. The affected surface is then wet with methyl blue, one gramme, alcohol and glycerine each five grammes.

To all parts stained blue, a light application of a solution of chromic acid, one to five, is made causing a purple color. The blue is now again applied and the surrounding parts carefully washed. To prevent crusts starch poultices or sublimate compresses are used. These applications are made four or five times, at intervals of two or three days; after which the blue is used alone until the skin no longer absorbs the color. For each square centimetre will be required about one month of treatment. Brilliant immediate results appear, and they seem lasting.

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**Chloroform Narcosis.**

Resuscitation in chloroform narcosis has been accomplished by a new method devised by Maas, one of Koening's assistants of Goettingen. In the first case, the ordinary means of resuscitation had been tried for an hour without effect; respiration and pulse has entirely ceased. Maas then made rapid rythmical compressions, about one hundred and twenty per minute, of the cardiac region, whereupon the hearts' action gradually increased and the patient recovered. A second severe case responded with the same result to the treatment. Mass ascribes the effect of the cardiac compressions to the driving of the blood into larger arteries.—*Chicago Medical Recorder.*

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Thymol in Toothache.

Dr. Hartmann (*Deutsche Med. Wochenschrift*) has employed thymol in toothache from hollow teeth, in place of arsenious acid. He fills the cavity of the tooth with a tuft of cotton on which a few crumbs of thymol have been sprinkled. It does not irritate the mucous membrane of the mouth much, and it is easily removed by rinsing the mouth with water. If a rapid action is desired let the patient rinse the mouth often, with warm water, in order to facilitate the solution of the drug. It never increases the pain at first, as arsenic does, and is not poisonous.—*Lancet-Clinic.*

### Hydrogen Peroxide a Hemostatic.

Brewer (*N. Y. Med. Jour.*) calls attention to this property of the drug. He has used it to arrest hemorrhage after operations upon the nose and throat and found it promptly effectual where other methods, including powerful chemical stiyptcs and plugging had failed. The ordinary fifteen volume solution is to be applied either on a cotton swab or sprayed directly upon the bleeding surface.

### The Treatment of Lupus by Salicylic Colloid.

E. Mansel Sympson, M. D., says for nearly five years I have used salicylic colloid in the treatment of lupus vulgaris affecting the skin.

The formula is as follows:

℞ Acidi Salicylici ..... 3j.
Extracti Cannabis Indicæ ..... gr. x.
Collodii Flexilis ad ..... 3j.
Fiat pigmentum.

It seemed so safe and so easily applied by unskilled persons, it caused so little pain comparatively, and the chances of its destroying the affected area of skin were so great, that I chose this form of applying salicylic acid in preference to any other, such as the plaister-mull or the salicylic plaister.

Much in the same way in which it acts on warts and corns (in which however the horny layer of the epidermis is equally predominant with the elongated and enlarged papillæ) it acts on lupus. Under its influence ulcerating patches dry up, tubercules disappear, and the resulting cutaneous tissue is much more flexible and natural in appearance than is generally the case in lupus.

One patient of mine has used it now for quite four years, and can take any situation without difficulty, the salicylic colloid keeping the disease in check. Indeed, this virtue of checking the return or advance of lupus is one of the chief reasons why I have brought this subject before the readers of the *Practitioner*. Nothing that I know of will *cure* lupus; often cases amend for a time and then progress no further. After scraping, for instance, and touching up with the cautery, great improvement may immediately ensue; but it is quite probable that there will be another outbreak at no distant period.

With salicylic colloid, however, the disease can be diminished and held back with ease. The constant need to repeat the application is of very small account compared with the dread of an operation. In one case I scraped thoroughly one side of the face in a well-marked subject of lupus, which Dr. Harrison had kindly handed over to me, painted the other with the colloid. Unmistakably the side painted got better quicker than the side scraped. Where the area to be painted is large, a little can be done every day, ensuring that each part of the diseased surface shall be painted about twice a week.

Although it scarcely comes within my heading, I may mention that for lupus of the mucous membrames I use the red oxide of mercury ointment.—*Practitioner.*

### Vinegar as a Remedy Against Vomiting After Chloroform.

Immediately after having performed the operation and placed the patient in bed, he (Warholm, in *Sattellite*) applies a handkerchief moistened with vinegar in front of the nose, letting it remain there until the patient returns to consciousness, or longer if it agrees with him. Of thirty cases experimented upon by the author, the majority were benefitted. In most of them the effect was absolute. In two cases the remedy did not succeed; one of these was an alcoholist. The patient should have a small phial, filled with vinegar, standing at his bedside, to smell as the demand arises.—*Southern Clinic.*

### The Treatment of Tuberculous Pleurisy.

Dr. William Osler states that the indications are twofold: First, to limit and control the exudate and to promote its absorption. In the early stage it is sufficient to allay the pain, if severe, with opium; to reduce the fever, if high, by sponging, and to keep the bowels freely opened. It is doubtful whether the salicylates deserve the confidence which many claim. While fluid remains in the chest it is for the good reason that it cannot get out, owing to blocking of the lymph paths. Absorption from the pleura goes on, chiefly if not entirely, from the costal layer. Good results are seen from putting the patient on a dry diet, and giving brisk saline cathartics. Diuretin, when it acts, is useful in the same way. If at the end of ten days the exudate persists, and is at the level of the fourth rib in the erect posture, aspiration is advisable, and this may be repeated in a few days if the fluid reaccumulates. There are

no greater risks in the tuberculous than in the simple sero-fibrinous cases, and it is very important to relieve the lung early of the compression to which it is subjected by any large quantity of fluid. The risk of the compressed lung becoming the seat of tuberculosis is not very great; more serious is the danger lest it should become bound down by such firm adhesions that it cannot expand. Gentle counter-irritation of the skin is probably beneficial in these later stages, stimulating the lymphatics of the costal pleura. In chronic sero-fibrinous effusion with thickening of the membranes, the fluid reaccumulates rapidly, and aspiration may have to be performed many times, and pulmonary gymnastics should be practiced. If the exudate be purulent the case should be transferred to the surgeon for thorough drainage. The second indication is to improve in every way possible the general nutrition of the patient, so as to favor conditions promoting the healing of the tuberculous process. No doubt, as in pulmonary and peritoneal infection, many instances of tuberculosis of the pleura recover, and leave no more damage than that associated with slight thickening of the membrane. A life in the open air, regular habits and exercise, a nutritious diet, and the use of the remedies which promote in every way digestion and the assimilation of food, should be advised.—*Transactions of the Massachusetts Medical Society*, 1893.

### An Easy Method of Keeping Warm.

I should like to call attention to an easy method of warming one's self when other and more common means are not available. It is a method that I suppose is well enough known to the profession, but probably not often used. I allude to warming the body by merely taking deep inspirations.

On the very cold afternoon of this winter, though walking briskly along, I was uncomfortably cold; feet and hands were very cold, and my ears so chilled as frequently to require the application of my heavily gloved hands. In addition, the whole surface of the skin was unpleasantly chilled; "creeps" ever and anon running up and down my spinal column and radiating thence over the body and extremities; in short, a condition that every reader of this little article has doubtless many a time experienced. I then began taking an exercise often employed before with benefit; deep forced inspirations, holding the air as long as possible before expulsion. After a few inhalations the surface of my body grew warmer, and a general sense of comfort pervaded me. Continuing, the next part to feel the effects of the effort was my previously frigid ears; they grew agreeably warm, and within the time required to walk three blocks, at the previous space, hands and feet partook of the general warmth and I felt as comfortable as if the same length of time had been passed by a glowing fire.

The happy results obtained from this simple method are probably owing to several causes:

The cold of course chills the surface of the body and contracts the superficial blood-vessels, usually affecting first hands, feet and ears, and afterwards the general body surface. Contraction of the blood-vessels results both in less blood to the part and in stagnation of the current, thus rendering the tissues still less able to resist the cold. Deep forced inspirations not only stimulate the blood-current by direct muscular exertion, but also by compressing and expanding the lungs, the flow of blood is greatly hastened through this organ, and on account of the increased amount of oxygen inhaled, this abundant supply of blood is thoroughly oxygenated, tissue metabolism is increased and more heat necessarily produced.

Many times unavoidable exposure as in riding, driving, standing and the like, for a longer or shorter time in the cold, has been the cause of severe and even fatal congestive troubles, such as pleurisies and pneumonias, and a means of quickly stimulating the flagging peripheral circulation which a person has always with him, and which can be employed without moving a step, is one that ought not be neglected or forgotten.—Ernest B. Sangree, M. D., in *American Therapist*.

### Treatment of Acute Urethritis.

In the first or increasing stage of an acute urethritis, whether specific or otherwise among the many plans of treatment, there is the well known one of increasing the amount of urine voided and conjointly with this rendering it alkaline. During this stage we have marked urethral symptoms, as ardor urinæ, chordee, etc. The following formula is much used in the service of Prof. Neilson, and I can say from a somewhat extended clinical experience with it, that it almost always accomplishes the object aimed at, namely; affecting the urine so that the urethral symptoms of the early stage of an acute urethritis are much modified:

℞
Potassii acetatis.....3iij
Potassii bromidi.....3iss.
Acidi borici.....3ij 6ij.
Tr. belladonnae.....3ss.
Sig. Potassii citratis, qs. ad.....3viii.

M. S. A teaspoonful in a goblet of water three or four times a day.

In giving your directions to the patient it is important that he understands he is to take a liberal quantity of water with his medicine and I think the remedy is better taken about two hours after meals.

The potash salts can be presented in such doses as the physician thinks best meets the immediate case. The boracic acid renders the urine to a degree antiseptic and I have never seen it produce any depression in the above dose—ten grains. The dose of belladonna seems to have a soothing influence on the mucous membrane. The formula given above is not original in any way and is only given as a combination, very effective in a large clinical service.—Dr. Lindsay, in *Philadelphia Polyclinic*.

### Some Practical Points in Infant Feeding.

Louis Fisher, M. D., in the *Amer. Medico-Surg. Bull.*, says: First, always try to feed the child with "its own" mother's milk. A child may receive both breasts alternately at one meal if the appetite warrants it. Never have a baby fed by the milk of its mother if the latter suffer with general debility or tuberculosis. Extremely nervous mothers should not nurse their babies.

Syphilitic babies (hereditary) can only be nursed by their own mothers, owing to the risk of infecting the wet-nurse. Very frequently the life of the child is dependent on its being nursed by its mother in syphilis.

(*a*) The return of menstruation is no contra-indication to the continuation of nursing.

(*b*) The moment a woman is pregnant nursing should be stopped.

(*c*) Children should not be nursed at night unless for some special reason.

(*d*) Weaning should take place gradually and only in the eighth to the tenth month.

(*e*) It is understood that weaning should not be commenced during the hot summer weather.

The main factor in determining the time of weaning is "weighing." Children must be weaned when, although in perfect good health, they remain below normal weight.

(*f*) Prolonged nursing (useless) will induce rhachitis (rickets).

2.—If, for various reasons, a child cannot be nursed by its mother, we then resort to the wet-nurse.

(*a*) She must be carefully examined as to her physical condition; tuberculosis, all chronic disorders and diseases would prevent proper nursing. Hereditary nervous troubles, epilepsy, syphilis, would exclude nursing.

Milk requires microscopical examination to determine amount of fat, the condition of the emulsion, etc.

(*b*) It is a good point to try to procure a wet-nurse suckling a child about as old as the one we wish her to nurse, although it is quite common to find nurses who have older children than the one they wish to nurse and to find the latter doing well.

(*c*) The proof of the usefulness of the wet-nurse is the condition of the baby after some time. If the child thrives it will increase in weight. Hence scales must be frequently used.

3.—Artificial substitutes for breast milk:

(*a*) Never give any food preparation containing *starch* during the first three months.

*Cows' milk.*—There is a great difference between human and cow's milk—hence we must dilute accordingly.

Dilute—in order to make it as near mother's milk as possible—by adding substances which will make the milk easily digestible and not curdling.

Alkalis and acids should not be used, or only to correct pathological conditions. Add farinaceous substances:

(*a*) Oatmeal gruel were constipation exists.

(*b*) Barley gruel where tendency to diarrhœa exists.

It is advisable to use shells of the cereals, as they contain a certain quantity of albuminoids.

Sugar is added by using sacch. lactis; salt is added by using ordinary table salt.

Certain dangers of feeding by cows's milk and their avoidance:

Possible transmission of tuberculosis, owning to which fact it is advisable to feed from several cows and not from a single cow—contrary to the general opinion.

The milk must be boiled, and thoroughly so, in order to destroy one of the most frequent contaminations, namely, micro-organisms.

Boiling methods have been improved upon by introduction of sterilization by Prof. Soxhlet, and since then by partial sterilization called pasteurization.

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### Treatment of Tuberculosis of Lungs.

Dr. Carasso reports thirty-nine cases treated with great success as follows: Continuous inhalations of peppermint-oil, internal administration of an alcoholic solution of creasote, glycerine, and chloroform and one per cent of peppermint-oil. Bacilli disappeared in from two weeks to two months. The bodily weight increased, the appetite improved, the cough, sweating and expectoration disappeared and the lungs apparently healed—*Gazetta degli Ospitali.*

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### Rheumatism.

Ointment of salicylic acid, turpentine and lanolin speedily relieved the pain of articular rheumatism, and reduced temperature to normal before the fifth day. No unpleasant effects, such as often follow large internal doses of the salicyl compounds. It is also valuable in subacute rheumatism and lumbago.—Bourget, in *Therapeutische Monatschifte.*

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### Oxalic Acid as an Emmenagogue.

Parlet strongly recommends oxalic acid for this purpose. He prescribes:

℞ Oxalic acid.....gr. xxx.
Infus. tea.....℥vi.
Syrup of orange peel.....℥vi.
M. S. ℥ss every hour.

It is especially at the expected time of the appearance of the menses that this is indicated. Under these conditions it surpasses all the other emmenagogues of the most repute. —*Times* and *Register.*

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## SURGERY.

### The Intravenous Injection of Saline Fluid.

In a minor editorial article the *Lancet* for January 13th says:

There can be little doubt that the injection of salt solution into the veins constitute a valuable addition to our therapeutic measures in certain otherwise hopeless cases. We re-

fer more especially to cases of severe accidental or unavoidable hemorrhage, to severe cases of post partum hemorrhage, as well as to cases of extra uterine pregnancy where there has been rupture of the sac with profuse intraperitoneal hemorrhage. It would seem that the injection is also indicated in some cases of severe operation where a large quantity of blood has been lost, but less than is needed to prove immediately fatal. In a certain proportion of such cases, although the patient is not pulseless at the end of the operation, death occurs before many hours have elapsed, apparently from secondary syncope. In some cases of this kind, at all events, it appears probable that the injection of salt solution may avert an unfavorable termination. It is certainly a great step in advance to have it established that the injection of actual blood is unnecessary; for so long as blood was thought to be required the practical difficulties surrounding the procedure were so great that it has but rarely been employed; and it is, in the light of our present knowledge, as certain as anything can well be that many lives have been lost solely for the want of some ready means of restoring the volume of the circulating fluid. It is evidently of great importance that the method should be a simple one, and especially that it should not involve the possession of some more or less complex apparatus which the ordinary practitioner could not be expected to have on hand. As regards the fluid to be used, the simplest of all—plain water—will do, since successful cases are reported in which water has been injected; but it is certainly preferable to use a solution of common salt, the proper strength being a teaspoonful of the latter to a pint of water. Here again, while it is no doubt desirable, if circumstances permit, that the solution should be sterilized, it is abundantly clear that it is by no means absolutely essential. A patient should not be allowed to die from loss of blood, where it is practically certain if let alone she would do so, merely on account of an extremely remote risk of septic poisoning from the water in the kitchen kettle and the salt in the table salt cellar. Then as to the quantity of fluid to be injected. This should depend upon the amount of blood that has been lost, but this often cannot be accurately estimated. It is important to note, however, that a few ounces are of little or no use. In cases really requiring this treatment it is a question of injecting pints. From a minimum of two pints in the less severe cases to a maximum of six pints in the worst cases in the amount of salt solution to be used. This should be continued till the pulse can be felt at the wrist. Opinions differ as to the rate at which the fluid should be injected; some consider that a pint in four minutes is not too fast, while others think that the rate of injection should be a third of this or less. Probably the actual state of depletion of the circulation causes the rate at which the injection may be safely made to vary in different cases. The temperature of the fluid used should be about the same as that of the body. The actual apparatus required consists only of a cannula and a few feet of India rubber tubing connected with a vessel to hold the salt solution. The form of the vessel is immaterial; indeed, the tubing, converted into a siphon, may be made to convey the fluid from an ordinary jug: Now that the whole procedure has been so much simplified, we may expect to hear of it being more frequently resorted to in the coming year. Certainly no patient should be allowed to die from hemorrhage without an attempt being made to save her by means of the intravenous injection of salt solution.

## ARMY AND NAVY.

U. S. ARMY FROM MARCH 17, 1894, TO MARCH 31, 1894.

Fessenden, C. S. D., Surgeon; detailed as chairman Board for physical examination of Asst. Surgeon L. E. Cofer, March 6, 1894.

Purviance, George, Surgeon; detailed as chairman Board to inspect Reedy Island Quarantine, February 20, 1894; to report at Bureau for temporary duty, March 2, 1894.

Hutton, W. H. H., Surgeon; detailed chairman Board for physical examination of Inspector of Hulls, March 9, 1894.

Gassaway, J. M., Surgeon; detailed as Recorder Board for physical examination of Asst. Surgeon L. E. Cofer, March 6, 1894.

Godfrey, John, Surgeon; detailed as chairman Board for physical examination candidates, Revenue Marine Service, March 6, 1894.

Irwin, Fairfax, Surgeon; to proceed to Paris, France, for special duty, February 24, 1894.

Mead, F. W., Surgeon; detailed as chairman Board for physical axamination of candidates, Revenue Marine Service, March 10, 1894.

Carter, H. R., Surgeon; to report at Bureau for special duty, March 14, 1894.

Banks, C. E., Passed Asst. Surgeon; to proceed to Portsmouth, N. H., as inspector, March 12, 1894.

Kalloch, P. C., Passed Asst. Surgeon; granted leave of absence for thirty days, March 12, 1894.

Glennan, A. H., Passed Asst. Surgeon; detailed as member Board to inspect Reedy Island Quarantine, February 20, 1894.

Wasden, Eugene, Passed Asst. Surgeon; granted leave of absence for sixteen days, March 3, 1894.

Kingyoun, J. J., Passed Asst. Surgeon; to report to Chairman Committee on ventilation and acoustics House of Representatives for special duty, February 21, 1894.

Woodward, R. M., Passed Asst. Surgeon; to report at Bureau for special duty, March 14, 1894.

Guitevas, G. M., Passed Asst. Surgeon; granted leave of absence for twenty days, February 19, 1894

Stimpson, W. G, Asst. Surgeon; granted leave of absence for twenty-five days, March 5, 1894; detailed as Recorder Board for physical examination of inspector of Hulls, March 9, 1894.

Houghton, E. R., Asst. Surgeon; ordered to examination for promotion, March 3, 1894.

Rosenau, M. J., Asst. Surgeon; ordered to examination for promotion, March 6, 1894.

Cofer, L. E.. Asst. Surgeon; to report to Board for physical examination, March 6, 1894; placed on "waiting orders," March 15, 1894.

Gardner, C. H., Asst. Surgeon; detailed as Recorder Board for physical examination of candidates, Revenue Marine Service, March 10, 1894.

Steward, W. J. S., Asst. Surgeon; detailed as Recorder Board for physical examination candidates, Revenue Marine Service, March 10, 1894.

## NEWS AND MISCELLANY.

### American Medical Association.

*San Francisco Meetings, June* 5-8, 1894.

SECTION ON SURGERY AND ANATOMY.

John B. Roberts, M. D., Philadelphia, Pa., Chairman. Lloyd W. McRae, M. D., Atlanta, Georgia, Secretary.

It is proposed to devote a portion of the time of this section to the systematic consideration of a few selected subjects, upon which papers, each not occupying more than ten minutes will be read. It is hoped that speakers discussing these papers will confine their remarks to brief addresses of five minutes' length. The topics and papers to be presented are as follows:

I. MALIGNANT GROWTH.—The Pathology of Malignant Growths: E. Laplace., Philadelphia, Pa. A Critique of the Sporozoan Theory of Malignant Neoplasms from a Micro-technical Standpoint: A. P. Ohlmacher, Chicago, Ills. Clinical Recognition of Malignancy in Tumors: C. A. Wheaton, St. Paul, Minn.; Henry W. Coe, Portland, Oregon. The Necessity of Early Surgical Interference in Malignant Tumors: R. A McLean, San Francisco, Cal. The Value of Caustics in Malignant Growths: John Parmenter, Buffalo, New York. The Radical Cure of Malignant Tumors by Operation: J. H. Wythe, Oakland, Cal. The Value of Inoculations with Septic or Toxic Agents in the Treatment of Malignant Neoplasms: John A. Wyeth, New York, N. Y.

II. TUBERCULAR DISEASE OF JOINTS.—Early Symptoms and Diagnosis of Tubercular Joint Disease: Emmet Rixford, San Francisco, Cal.; A. B. Judson, New York, N. Y. Conservative Treatment of Tubercular Joints: R. H. Sayre, New York, N. Y.; Harry M. Sherman, San Francisco, Cal; James E. Thompson, Galveston, Texas. Operative Treatment of Tubercular Joints: Robert W. Lovett, Boston, Mass. Treatment of Tubercular Joints by Injections of Iodoform: N. Senn, Chicago. Treatment of Tubercular Joints by Injections of Corrosive Sublimate: R. H. Plummer, San. Francisco, Cal.

III. HERNIA.—The Causation and Prevention of Hernia: James T. Jelks, Hot Springs, Arkansas: C. M. Richter, San Francisco, Cal. The Management of Reducible Hernia: Emory Lanphear, Kansas City, Mo.; C. M. Fenn, San Diego, Cal. The Treatment of Irreducible Hernia: James B. Eagleson, Seattle, Washington. The Treatment of Strangulated Hernia: Joseph Ransohoff, Cincinnati, Ohio. The Radical Cure of Hernia: W. E. S. Davis, Birmingham, Ala.; H. O. Marcy, Boston, Mass.

IV. HEMORRHOIDS, FISTULE AND FISSURE.—The Pathology and Symptamology of Hemorrhoids, Anal Fistule and Anal Fissure: J. M. Matthews, Louisville, Ky.; David Powell, Marysville, Cal. Treatment of Hemmorrhoids: H. M. Bishop, Los. Angelos, Cal.; Charles B. Kelsey, New York, N. Y. Treatment of Anal Fistule: J. McF. Gaston, Atlanta, Ga.; G. B. Somers, San Francisco, Cal. Treatment of Anal Fissue: Thomas, W. Huntington, Sacramento, Cal.; Lewis H. Adler, Jr., Philadelphia, Pa.

V. FRACTURES.—Treatment of Fractures of the Lower End of the Humerus: Oscar H. Allis, Philadelphia, Pa. Treatment of Fractures of the Lower End of the Radius: P. T. Connor, Cincinnati, Ohio: C. L. Bower, Philadelphia, Pa. Treatment of Fractures of the Neck of the Femur: Bedford Brown, Alexandria, Virginia. Treatment of Gunshot Fractures: George A. Goodfellow, Tucson, Arizona. Treatment of Fractures of the Shaft of the Femur: Llewellyn Eliot, Washington, D. C. Treatment of Open or Compound Fractures: H. H. Mudd, St. Louis, Mo.; John B. Hamilton, Chicago, Ills.

VI. Obstruction to Urination in the Male.—Effects of Obstruction in Urination Upon the Bladder and Kidneys: J. William White, Philadelpdia, Pa. Diagnosis and Treatment of Enlargement of the Prostate Gland: Hunter McGuire, Richmond Va.; Wm. T. Belfield, Chicago, Ills. Symptoms and Treatment of Stone in the Bladder; William T. Briggs, Nashville, Tenn. Symptoms and Treatment of Tumors of the Bladder: John B. Deaver, Philadelphia, Pa.; C. F. Buckley, San Francisco, Cal. Treatment of Stricture of the Urethra: J. Rosenstirn, San Francisco, Cal.

Members who have specimens or patients to exhibit bearing on these topics, or who wish to make remarks in the discussion of them are cordially invited to be present during the meetings of the Section. The titles of other papers to be presented to the Section will be published when the programme of the Meeting of the Association is issued by the Committee of Arrangements.

JOHN B. ROBERTS,
1627 Walnut street, Philadelphia, Pa.
Chairman Section on Surgery and Anatomy.

### American Surgical Association—Session of 1894.

SPECIAL SUBJECTS FOR DISCUSSION.

*I.* "*Surgical Treatment of Empyema.*"

BY JOHN ASHURST, JR., M. D.

SUMMARY.

1. No operation is justifiable unless the presence of pus is certain; unless thorough treatment by medicinal agents, blisters, etc.,

has failed; or unless the symptoms, dyspnœa, etc., are so urgent as to demand immediate relief.

2. The first operation should consist of simple aspiration, with antiseptic precautions.

3. When the fluid has partially reaccumulated, as it almost certainly will do if purulent, incision and drainage should be practiced.

4. Drainage is best effected by making two openings, one at the lowest point, and carrying a large drainage-tube through the cavity from one opening to the other.

5. Drainage should be supplemented by washing out the cavity with mild antiseptic fluids; when the lung has expanded and the discharge has nearly ceased, the tube should be shortened, the upper opening being allowed to heal, and the tube then being gradually withdrawn through the lower opening.

6. When the lung is so bound down by adhesions that it cannot expand, resection of two or more ribs should be practiced (Estlander's operation, so-called), in order to allow collapse of the chest wall and to promote healing by bringing the costal and visceral layers of the pleura into contact.

7. The more extensive operations of Schede and Tillmans, while probably justifiable in exceptional cases, are not to be recommended for general employment.

The discussion of the paper will be opened by Drs. N. P. Dandridge, C. B. Dancrede, T. F. Prewitt, and De F. Willard.

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*II.* "*Methods of Teaching Surgery.*"

BY J. S. BILLINGS, M. D.

SUMNARY.

Two classes of students. 1. Undergraduates. 2. Those wishing to make a special study of Surgery.

For the first class, work of teaching divided between Professors of Pathology, of Surgery, and of Clinical Surgery, and Demonstrators.

What shoud be the relations between these and the teachers of Gynecology, Orthopædic Surgery, Genito-Urinary Surgery, etc.?

Methods of teaching. 1. Didactic lectures. 2. Recitations. 3. Demonstrations by means of manikins, cadavers, operations on animals, etc. 4. Clinical lectures to large classes. 5. Practical clinical instruction to small classes.

How far should the didactic teaching be subordinated to clinical and demonstrative teaching?

Relations of hospitals to clinical teaching. Instruction in History and Literature of Surgery.

Provisions to be made for special students.

The discussion of the paper will be opened by Drs. J. C. Warren, N. Senn, W. W. Keen, E. M. Moore, W. T. Briggs, and Hunter McGuire. It is desired that the discussion of this paper should be participated in by the Fellows generally.

"*The Surgery of the Kidney.*"

BY L. M. TIFFANY, M. D.

SUMMARY.

1. Influence of disease of kidney on general surgery.
2. Nephritis.
3. Pyelonephritis.
4. Nephrolithiasis.
5. Nephrectomy, partial and complete.

The discussion of the paper will be opened by Drs. M. H. Richardson, H. H. Mudd, C. H. Mastin, and Ford Thompson.

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*IV.* "*Methods of Controlling Hemorrhage in Amputation at the Shoulder,*" *as illustrated by three cases of amputation at the shoulder-joint and of the entire upper extremity.*

BY W. W. KEEN, M. D.

SUMMARY.

1. Amputation at the shoulder-joint with the use of Wyeth's pins.
2. Amputation at the shoulder-joint with preliminary ligation of the vessels in the interspace between the deltoid and the pectoral muscles.
3. Resection of the clavicle and securing the vessels, followed by amputation of the entire upper extremity, including the clavicle and scapula.

The discussion of the paper will be opened by Drs. Roswell Park, C. B. Porter, and J. William White.

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V. PAPER BY HUNTER MCGUIRE, M. D.

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VI. PAPER BY JOSEPH RANSOHOFF, M. D.

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Fellows who desire to present volunteer papers are requested to send the titles of the papers to the address of the Business Committee, 1429 Walnut Street, Philadelphia, not later than April 18th, 1894.

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The sessions of the Association will be held in the Lecture-room of the Medical Department of the Columbia College, 1325 H Street, N. W., Washington, D. C., on May 29th, 30th, 31st, and June 1st, from 10 A. M. to 1 P. M.

The sessions of the Congress will be held in Metzerott's Hall, corner of Twelfth and F Streets, N. W., in the afternoon from 2 to 5 o'clock.

The office of registration of the Congress will be at the Arlington Hotel. Registration of individual members of the constituent associations of the Congress is necessary to make them members of the Congress.

Dinner to the guests of the Congress at the Arlington Hotel, Wednesday, May 30th, 7 P. M.

Reception by the President of the Congress, Thursday evening, May 31st.

J. R. WIEST, M. D., *Secretary.*

THE

# MEDICAL AND SURGICAL REPORTER.

No. 1936. PHILADELPHIA, APRIL 7, 1894. Vol. LXX—No. 14

## ORIGINAL ARTICLES.

### DIABETES MELLITUS, WITH REPORT OF TWO CASES.*

GEO. F. BATES, A. M., M. D.,† Hillsboro, N. D.

In entering upon a discussion of the above subject, I am aware that in all probability, I shall have nothing new to offer as regards either etiology, pathology or the treatment of the disease. However, in bringing out the history of two of my cases, I think the majority of physicians will find *symptoms* which will prove as new and interesting to them as they have to me.

I pass rapidly over the causes of this disease. Theoretically, it has been traced to derangements of various organs; in fact, there is hardly an important organ in the body which has not at some time or other been accused of being the seat of changes, which either directly or indirectly, have laid the foundation for the disease known as diabetes. It is a disease of whose very nature we are ignorant. Are not the great majority of autopsies from which our data are collected, held upon bodies of those who were in the shadow of death before their disease was recognized and treated?

Has the morbid anatomy of the liver, the medulla, the pancreas or the kidneys, ever been studied at the time when sugar first appeared in the urine? What physician, as a rule, ever sees these cases in their incipiency? Who shall say, therefore, which of all these morbid changes described to-day in our textbooks, are the causes and which the results of this disease? It appears from quite an extended research that most authorities concur in the opinion that derangement (either functional or organic) of one or all of the above mentioned organs is an important factor in the causation of diabetes —this *bete noir* of the profession. Much has been said in favor of each theory and nothing decisive in favor of any. So we are at liberty to go over the field and choose for ourselves which theory we will adopt.

I long ago chose to accept the theory of its nervous origin, and I have not done this from any extended pathological investigations, but from a careful observation of the effects of different drugs upon the disease itself. It is true that we often, yes usually, find functional and organic changes in some of the other organs, such as the liver, pancreas, lungs and kidneys, but all of these are easily explained as being *results* of deranged innervation, not *causes* of the disease in question. So in the treatment we are compelled usually to employ remedies directed to the relief of these conditions as *adjuvants* merely to the main line of treatment, which I claim to be the exhibition of nervous tonics or sedatives according to the indications in each particular case.

Pathologically considered, the disease presents no constant lesions. We find the liver sometimes enlarged and fatty, sometimes small and cirrhotic. The pancreas occasionally is fibroid and cirrhotic, sometimes fatty, and frequently perfectly nor-

*Read before North Dakota Med. Association, 1893.

†Late Professor of Materia Medica and Therapeutics, College of Physicians and Surgeons, Minneapolis, Minn.

mal. The nervous system, both sympathetic and cerebro-spinal, presents some lesion or other almost invariably; sometimes a tumor, sometimes a sclerosis, often cysts, and in some cases we find a well defined neuritis. The lungs and kidneys also present various changes, but nothing which may be said to have a causative relation to the disease.

A few words now in regard to the symptomatology of diabetes. As a rule, I think, the younger members of the profession are apt to be deceived by the usual picture of the disease as given in our standard medical works. It is described as a nutritive disorder, attended by an excretion of sugar in the urine, which is usually increased in quantity. They inform us that we are to look for something similar to the following: Intense thirst, accompanied by the excretion of immense quantities of saccharine urine, the amount of this urine bearing some definite ratio to the quantity of water ingested; rapidly progressive emaciation; a voracious appetite, sometimes amounting to polyphagia; gums red and swollen; teeth loosened; aphthous stomatitis; urine sweet to taste (who of you have tried this test?); and a host of other distressing symptoms gradually ending in coma and death. Now let me ask if this is a fair picture of the majority of the diabetic cases which are met in actual practice? If so, such experience differs from mine. It is true we have all seen cases which answered fully this description, even worse, but I ask candidly if the above picture is not that of the patient who has for years wandered from one physician to another, being treated for this and for that, first for the stomach, then for the liver, next for the kidneys, and so on until finally he has come into our hands at an incurable stage of the disease. All, perhaps, because a thorough and a careful analysis of the urine had been omitted at the outset.

Our authorities tell us but little about the early symptoms of the disease, so the young practitioner is taught to consider the above a typical picture of the diabetic patient. It is for this type of the disease, then, that he is expected to give his immense doses of opium, morphia, codeia, and so forth. Diabetes is usually classed among the incurable diseases, and even as great an authority as Osler says: "Personally I have never seen *recovery* from a case of true diabetes." This is from a man who has had wide experience both in hospital and private practice. Still with all due respect to the experience of Prof. Osler and others high in authority, I must believe that this opinion is founded upon an examination of cases, the majority of which must have been in the advanced stages of the disease.

As evidence of the curability of diabetes when recognized in its incipient stage, I will give briefly the history of two of my recent cases. Remember, I do not claim anything new or original in my method of treatment, nor will I say positively that *all* the symptoms I observed were caused by this diabetic tendency; but if I have made an error in my diagnosis I wish to be shown it, as it is but poor satisfaction to rightly treat a wrong disease.

However, the cases were, after a thorough investigation, diagnosed to be diabetic in their nature, and were treated as diabetic, and both have recovered. There is an old saying, "the treatment of ten establishes the diagnosis," so, in these cases the treatment, if nothing else would tend to confirm my judgment.

Case I. Mrs. T., aged twenty-nine years, came under observation in October of 1892. Consulted me principally for the relief of indigestion and headache. I found her fairly well nourished, but very anæmic, with furred tongue, nausea, marked anorexia, constipation, and liver somewhat enlarged and tender. On inquiry I learned that she had been under treatment nearly all of the previous winter and summer for what she termed "stomach trouble," but no appreciable change in her condition except for the worse. Up to the time of consulting me, no examination of the urine had ever been made, and let me suggest here that this is an omission we should never be guilty of. It seems to me that no diagnosis should be made in doubtful cases, or treatment entered upon, until a careful urinary examination has been made. It is a matter which is too often neglected in the hurry of practice, but which if carefully attended to, would clear up many of our previously obscure cases.

The obstinacy of her "stomach trouble" at once directed my attention to the kidneys, and this is what I found. She thought possibly there was a slight increase in the amount of water as she had

to rise at night often. Complained of a slight pain in the region of the kidneys, and also that she suffered from pruritus vulvæ somewhat. On October 19th I examined her urine and found the following: "Specific gravity, 1038; reaction strongly acid; color, a light amber; quantity for twenty-four hours, five pints; an excess of urea, no albumin; but of sugar a trifle over one per cent. To be more certain, I examined the urine every day for a week, meanwhile giving a placebo, and each time I found practically the same condition. Each time I employed three tests: first using the bismuth test, next Bartley's cannine-indigo and sodii carbonate powders, and lastly corroborated these with the old standby, Fehling's Solution, thereby eliminating all possibility of error. At the end of the week I began with the following:

℞ Strychine sulph.....gr. i
Podophyllin.....gr. viii.
Codoeia sulph.....gr. xx.
Papoid.....gr. xxv.
M. et ft. capsul, No. XL.
Sig. One after each meal.

You see there is nothing new or original about the prescription. I gave the strychnine and codeia for their well-known effects upon the nervous system, the derangement of which I think to be the chief cause of diabetes, and merely added the other ingredients to try and correct the condition of the stomach and liver the more rapidly. I do not know how the codeia acts in helping to control the disease, but I gave it as being the recognized treatment, and it undoubtedly has some special controlling influence over it. Be that as it may, my patient began to improve from the first under this treatment combined with a strict diet. Sweets and starchy foods of all kinds were forbidden. Gluten flour was substituted in place of ordinary flour. I saw her from time to time for examination each week. Her general condition improved rapidly, her strength returned, the quantity of sugar diminished gradually, the stomach and bowels regained their tone, the pruritus disappeared, the amount of urine lessened steadily, and night calls for micturition ceased entirely. This treatment was continued with gradually increasing doses of codeia and strychnine, until one-twelfth grain of the latter and two grains of the former were given three times a day, while the podophyllin was gradually withdrawn, as the liver resumed its normal functions. My examination of the urine the first of February, 1893, showed the specific gravity 1022; reaction slightly acid, color somewhat deeper, quantity for twenty-four hours two and one-half pints, urea normal, no albumin, no sugar. She at this time appeared and felt perfeclty well, with the exception that the anæmia still persisted. I then put her on Blaud's pills after meals, with a bitter tonic before. Under this treatment she rapidly regained her color, and at this writing she is apparently as well and healthy as ever in her life. I have examined the urine occasionally since then, but no trace of sugar has ever appeared. I have advised the husband to have her water examined at intervals for a year or more, and I think if ever sugar should reappear, that prompt treatment would be as satisfactory as before.

Case II.—Mr. S, aged thirty-eight years. The description of this case will not detain you long, as the treatment was identical with that of the previous case, with this exception that the strychnine was more rapidly pushed and the maximum dose (one-twelfth of a grain), was kept for a while by itself after all sugar had disappeared from the urine. This patient was a strong, robust, looking man and weighed one hundred and seventy-six pounds. He was well to do, was a good liver, had outdoor occupation, digestion good, bowels regular and was to all appearances a perfectly healthy man. He consulted me for the following symptoms: For several years he had noticed a growing weakness of his eyes, as he called it; could not confine his gaze to any one object for more than a few moments at a time; he had also noticed that sexual connection had quite a marked effect upon his eyes, claiming that for twenty-four hours or so after having sexual intercourse his eyes bothered him much worse than at any other time. He described the sensation as not an actual pain, but as more of a shrinking from light or bright objects.

He showed me in addition an oval ulcer on the edge of his tongue which had bothered him more or less for several years. He complained of a slight pain across the kidneys and about the loins, increased by riding. His kidneys acted rather freely, but he was never troubled at night. He informed me that he had his eyes examined in different cities, both in

the west and in the east by competent oculists, and he had been fitted with glasses by several but no relief of this condition. At the time of his visit to me he was wearing glasses adapted to hyperopic astigmatism. The right lens +50 +90°, the left was +25. He had also consulted several physicians relative to the ulcer on his tongue, and they had prescribed numerous local applications without any results. It was this last symptom, this sore tongue, which turned my attention toward the urine, as I have always made it a rule to examine the urine in all cases of obstinate sore mouth, and have several times been rewarded with finding there traces of sugar. The next day I examined his urine, and found as nearly the classical diabetic urine as ever I expect to see. Specific gravity 1040; reaction acid; one gallon passed in twenty-four hours; slight trace of albumin; urea increased; and lastly nearly two per cent of sugar. I submitted the urine repeatedly to the same tests as mentioned in the previous case, always with the same result, and afterwards during the treatment it was examined every ten days. He was put upon practically the same treatment as described in my first case, with the result that he soon began to improve in every respect. The sugar gradually diminished in quantity, finally at the end of about four months disappearing entirely; the specific gravity at this time showed 1024; the ulcer on the tongue healed completely without a particle of local treatment; his eyes gradually grew stronger and sexual intercourse ceased to have nearly the effect upon his vision as formerly, although this symptom has never wholly yielded.

As soon as the sugar disappeared from his urine, I discontinued the codeia, and gave him simply strychnia and quinine in doses of one-twelfth grain and one grain respectively, advising him to continue their use for several months longer. I have since examined his water from time to time and have invariably found sugar absent and his condition remaining good, with eye sight still improving under the use of the strychnia. At the time of writing this paper he informs me the improvement still continues, and it has been over a year since the codeia was dropped.

The symptoms of this last case are not such as are generally enumerated among those of diabetes, but if this disease was not the cause behind them, why should recognized diabetic treatment have such a marked influence in relieving them? I do not claim that sexual intercourse affecting the eyes is a symptom peculiar to diabetes, but I do not think that this disease was the direct cause of weakening the eyes so that this reflex ocular neurosis was more readily caused by sexual excitment.

## CONGRATULATORY ADDRESS.

THEOPHILUS PARVIN, M. D., PHILADELPHIA.

It is a pleasure to participate in these exercises. It is an honor to address this audience. But honor and pleasure are added in the duty of congratulating the Columbia District Medical Society upon its Seventy-fifth Anniversary.

The society was born in 1819! That was the birth-year of England's Queen, Victoria, and unto you, not by accident or by hereditary right, but by achievement, belongs the name of victory. Ten years earlier than the birth of this society was that of England's great Prime Minister, Gladstone. So too, in 1809, England's greatest poetess, Elizabeth Barrett, was born. That same year gave our country one who was destined to be among the wisest and most patriotic of Presidents, Abraham Lincoln. It was the natal year, too, of one who, entering the medical profession, did more by his contributions to a medical journal half a century ago, to avert "a private pestilence" from mother and her new-born, than all the obstetrics in the country; who for many years was an eminent teacher in Harvard, and still more distinguished for his contributions to literature, so that his name is honored wherever the English language is spoken — Oliver Wendell Holmes. Your organization is ten years younger than he who guides the destinies of one of the world's greatest empires— ten years younger, too, than he who is one

of the best and most honored of the world's teachers, and who, by his recent lines upon Francis Parkman, has proved that his mind is not clouded or his heart chilled in his ninth decade.

Yet seventy-five years is a long time in the history of a society in this nation, that only a short time since celebrated the centennial of the adoption of its constitution. The College of Physicians of Philadelphia is but thirty-two years older. The number of its active Fellows is 281, and since its organization these have been 586. Its chief pride is in its library, now numbering almost fifty thousand volumes, and its annually published Transactions. You have had 564 members, and now have 214. In view of such facts one must question the truth of Addison's remark, "We may lay it down as a maxim that when a nation abounds in physicians, it grows thin of people." I am quite sure that I echo the sentiment of every Fellow of the college in hearty congratulation for what you have accomplished, and in bidding you God-speed.

But for the moment I must speak, not for one, but for all the medical organizations invited to participate in this commemoration, in their name bearing meed of praise, and bringing new laurels to crown you this festal night. Nay, more, I imagine there comes from the entire profession of this country, from Maine to Texas, from Massachusetts to California, borne hither from either ocean, sweeping over mountain and valley, over city and hamlet, over prairie and forest, lake and river, harmonious and enthusiastic plaudit.

Every student of American medical literature knows well how many valuable contributions have come from members of this society, come, most of them, probably because of its existence. Washington men have been the authors of several medical text-books; among the more recent, one upon materia medica, the other upon obstetrics, have received deserved fame and position. Among the men who have helped me in the special department of medicine, which for years has almost exclusively engaged my attention, several of the Washington profession, some living, others dead, are included.

Thrice the great National medical organization of this country, the American Medical Association has chosen its president from the members of this society—these were in order, Lindsley, Toner and Garnett; minor positions in the association are every year assigned to Washington men.

It is hardly expected that I should speak of the more eminent dead of your number, among these, Noble Young, the Mays, Bohrer, Thomas Miller, Sewall, W. P. Johnston, Stone and James C. Hall. Of the last in this list permit me a word. I am informed that he attended more eminent men than any physician ever living in this country. At one time in his very active life he was the physician of every Judge of the United States Supreme Court, almost every Senator, many Representatives, the President and his Cabinet, and of nearly every Foreign Embassy. He was not only a great and successful practitioner but a true philanthropist, relieving distress kindly, liberally, unostentatiously. In doing alms he obeyed the Divine injunction, "Let not thy left hand know what thy right hand doeth." We may call him and his compeers,

> "The kings of ancient days,
> The mighty dead, who live in endless praise."

Pardon me if, prompted by many years of personal friendship, I refer by name to two of the living members of the Society in words of loving, and, I believe, just, praise. You, Dr. Busey, have recognized through your many years of busy life, that you were "a debtor to your profession," and honorably and well have you discharged that debt by contributions of sterling value to its literature, and by always seeking its interests possibly sometimes at the sacrifice of your own, but even then, and thus helping others to believe that, as Renan has said, the noblest thing in life is sacrifice. In view of your life and work, permit a layman to repeat a Pagan prayer, first uttered nearly three thousand years ago—may it prove prophecy as well as prayer:

> "So peaceful shalt thou end thy blissful days,
> And steal thyself from life by slow decays;
> Unknown to pain in age resign thy breath,
> When late stern Neptune points the shaft with death;
> To the dark grave retiring as to rest.
> Thy people blessing, by thy people bless'd."

One whose genial manners, generous heart and kindly deeds have endeared him to all who know him; one who has made for himself a name in the profession by important historical researaches, and by

his large and valuable collection of medical works donated to the public,* has taken no step to perpetuate his name by descendants, unlike the first May, whose son became a physician, and whose son's son is now treading in the footsteps of illustrious father and grandfather. But let us find comfort in the words of Bacon: "Certainly the best works, and of greatest merit for the public, have proceeded from the unmarried or childless men, which both in affections and means have married and endowed the public." Married and endowed the public! None forbade the banns, when this member of your Society, not letting his "thoughts end with himself," and not "accounting future times impertinencies," married and endowed the public. Though Dr. Toner has never "given hostages to society," may he long be spared to contribute to public and professional interests, still wearing his favorite flower, a bachelor's button!

How Washington has changed since your professional progenitors instituted this Society. A town of 12,000 is now a city of more than a quarter of a million. I have read that not long before 1819, congressmen had difficulty in finding lodgings, and that the wife of the President at one time, used the audience room of the White House as a place for drying clothes. One can believe that now it is difficult for many lodgings to find congressmen, and, as to location for drying White House washing, that if Mrs. Cleveland were to do as Mrs. Adams did, there would be a social, if not a political convulsion, and a very uncivil war. There have been great changes here and elsewhere since 1819, changes affecting material comfort, changes in manners, customs and external observances of society. But all departures from the old are not necessarily improvements, and all re-formations are not inevitably reformations; changes may be external, superficial, and not involving essential character and nature. "When Plancus was consul," was our social life worse than at present? The bowie knife and Bladensburg are memories only now, but are assassins and stilettos unknown at the end of the century, and are those who carry the poison of asps under their tongues all dead? Are there not still selfish, unscrupulous schemers, or vile ingrates who rob, or revile a benefactor, shrinking from no falsehood, however base to blacken his name, as long as they can work in the dark. When "Plancus was consul" possibly they would have been promptly called to account for their evil words and deeds. Children may not play marbles upon the front pavement on Sunday, especially when the devout are going to or returning from worship, but the back yard possibly is crowded by urchins, careless of the concealed fractures of the day that escape clerical observation and diagnosis. "When Plancus was consul," was the doctor a better man than to-day, better qualified for his work, with a nobler ideal of his calling, scorning "the tricks of the trade"—the indirect advertising through newspapers for example, which we now sometimes see, a doctor rushing into print upon the slightest occasion, or making known to reporters, eager for news, his professional exploits? There are doctors who will do anything to get talked about, to have public attention directed to them in order to secure public patronage. Yes, before those days of Plancus, to which reference has been made, we are told of doctors who "ply for employment like scullers at Hungerford stairs." Are there not doctors who do this now? Read, too, Smollett's story of "Count Fathom" starting in practice in London,† and the observation of almost any one will give him instances of its essential repetition. The count bought a chariot for "equipage, though more expensive than his finances could bear, he found absolutely necessary to give him a chance for employment; as every shabby retainer to physick in this capital had provided himself with such a vehicle, which was used altogether by way of a traveling signpost, to draw in customers; so that a walking physician was considered an obscure peddler, trudging from street to street, with his pack of knowledge on his shoulders, selling his remnants of advice by retail.

*Congress in acknowledgment of the doctor's present to the Nation of 28,000 books and 18,000 pamphlets, ordered both his bust and portrait to be made and placed in the Congressional Library—a just and honorable recognition of his great and generous gift.

†Dr. Samuel Johnson, in his biography of Akenside, after stating that this doctor and poet never attained professional success in London, remarks: "A physician in a great city seems to be the mere plaything of fortune; his degree of reputation is, for the most part, casual; they that employ him know not his excellence; they that reject him know not his deficience. By any acute observer, who has looked on the transactions of the medical world for half a century, a very curious book might be written on the "Fortunes of Physicians.'"

Though so many changes that are merely external, not touching the heart, not affecting the real life and character, but having to do merely with the clothes that are worn, have occured I believe in social, as much as in the certainties of medical progress: Faith in man, faith in God, would perish if I did not have this trust.

Certainly medicine has its imperfections, its defects and failures. But let us recall what one of our guild, Sir Thomas Browne, said in answer to this reproach: "There are not only diseases incurable in physick, but cases indissolvable in law, and vices incorrigible in divinity."

It may be objected there are quacks in medicine. Such fact is not peculiar either to the age or to the calling. Izaak Walton wrote more than two hundred years ago, "There are too many foolish meddlers in physick and divinity, that think themselves fit to meddle with hidden secrets, and so bring destruction to their followers." More than one hundred and fifty years have passed since Smallette declared, "We have quacks in religion, quacks in law, quacks in patriotism, quacks in government."

Our call my brothers of the profession, is to do our duty to our patients, to our profession, to society, and to God, come reward or reproach, whether our pathway is upon the mountain or in the valley, to live noble lives, even though making sacrifice and enduring trial, bravely and conscientiously seeking that the world shall be better on account of our living in it. When in Scotland the fiery cross was borne swiftly as strong and agile limbs could go, to the nearest village, and there given in charge of the oldest male representative of the family, the only word spoken was to tell the place of rendezvous, and it was his duty to carry it to the next village, there finding a new bearer of this consecrated emblem, and thus on until all the members of the clan were called to the mustering-place—no one could refuse the duty of bearing this cross—new-made bride or unburied father was not excuse—and unto those who failed to respond to the call, the cross became a cross of shame. The doctor bears a cross of fire in life's race, and only when that cross "drops from his nerveless grasp," and his weary feet falter, and forever fail, is his duty done.

Medicine comes more and more to the front every year, and especially is its power of preventing disease more distinctly recognized. When will our national legislators acknowledge the fact that the health and lives of the people are as important objects for their consideration and care as post offices and pensions, and the products of forest and farm, of mine and manufactory? When will they establish a department of public health, and place it under the control of a competent medical man, who shall hold equal rank and dignity with the heads of other departments of government? This duty is imperative, and this action ought to be immediate.

In final words I might eulogize the work of the physician, and exhault the honor of medicine. And to this end there could be adduced from Pagan and Christian writers, from the wisest and best of every age, testimonies that would be conclusive. But time does not permit, and I only ask you to listen to the eloquent words of Cardinal Newman, and see how appropriately and necessarily medicine is embraced in his large inclusion: "All that is good, all that is true, all that is beautiful, all that is beneficent, be it great or small, be it perfect or fragmentary, natural as well as supernatural, moral as well as material, comes from God."

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**Very Small, Indeed.**

The smallest baby yet reported was born in Killingworth, a village about eight miles west of this place. The parents are Swedes. The father is employed by a farmer cutting timber and weighs about 190 pounds. The mother is a stout, healthy woman, weighing perhaps 160 pounds. The child is a male as perfectly formed as any being can be, and on its birth weighed only eight ounces.

Its face is about the size of a horse chestnut. A ring worn on the little finger of its mother was easily slipped over his foot nearly up to the knee. It is the opinion of the attending physician that the child will live. The child is so small that three of its like could play hide and seek in a cigar box.—Ex.

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WHISKEY, in its relation to the human constitution, is unconstitutional.

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PEOPLE will continue to borrow trouble even when they know it is Lent.

# COMMUNICATIONS.

## A BRIEF STUDY OF SOME ANCIENT EPIDEMICS AND THEIR RELATIONS TO INFLUENZA.

### WITH NOTES OF THE EPIDEMIC OF 1893-94, AND RECENT METHODS OF TREATMENT.*

ROLAND G. CURTIN, M.D., AND EDWARD W. WATSON, M. D.†

The question of the identity of the cases of excessive sweating seen frequently in the last four years with influenza, is scarcely open to dispute; since the cases observed, either the initial symptoms were those of influenza or the sweating was evidently a sequel to a well-marked influenzal attack. All influenza, as a rule, was marked by relaxation of the skin, after the initial period and the subsidence of the earlier symptoms, and this often continued in a mild form (sweating on slight exertion, sweating when in bed, and on slight exposure to cold) for days and weeks. But the cases directly under consideration were marked by such excessive relaxation, and so entirely different from any previously observed in any other disease (except, possibly, in rare cases of convalescence from malarial and rheumatic disease, from which latter they differed in the odor of the perspiration), that they could not but strike the observer as unique.

We might add that since the epidemic sweating in phthisis has been much aggravated, as well as in other diseases. This may be explained as a condition like the other general catarrhal conditions, a hydrorrhœa, or, what might be termed for the want of a better name, a cutaneous catarrh of the sudoriferous glands.

In the early epidemic of 1889–90 a number of cases were observed in which there was this tendency to a remarkable degree, continuing for weeks, without emaciation or exhaustion or induced anæmia. These cases often perspired to such a degree that in cold rooms they seemed enveloped in steam, and at times as they were observed in bed, the ear which was uppermost and the corresponding hollow of the cheek were often full of water. At times the sweat extended into the mattress, and from below upward the moisture would outline the form of the patient on the coverlid.

In one case this condition lasted one week; in another four weeks; in another three months; in others five months; and in two six months; and one case affected a year ago, even now on slight exposure to cold continues to sweat profusely.

Many practitioners alluded in conversation, or in periodical medical literature, to similar cases, one writer in the South reporting an epidemic in his locality of what he termed a "sweating fever," and in the communication referred to asked information as to its nature. From the description given it was evidently something more than ordinary epidemic influenza, or simple catarrhal fever as usually observed, but resembled closely some of the cases seen by the writers in the past four years. Our cases generally began with an attack of influenza, or had some of the complications and sequelæ of influenza, viz.: the pulmonary or cardiac symptoms (angina pectoris, pericarditis, and heart failure), or affections of the peripheral nerves of one or both arms, rheumatoid pains, meningitis, diarrhœa, and other catarrhal affections and insomnia. With this profuse sweating the temperature night and day was generally near the normal—often either merely a little above or below. In one case for two months perspiration continued with the temperature from ½ to 1° below normal. Another case was noticed similar to the above.

It is very easy to understand from what we have seen of influenza, that in different periods of an epidemic, different structures may be predominantly affected, viz.: an epidemic of influenza, in which cardiac symptoms predominate, might, under depletion and the unwise use of depressants, come to resemble the so-called "cardiac disease" of ancient times; or where the vasomotor nerves especially suffered, under like improper management—over-heating, excessive covering, and the abuse of diaphoretics—a genuine "sweating sickness" might be produced; or the extreme

* Read before Phil. County Med. Soc., February 28, 1894.

† A portion of the paper will be published in the Transactions of the Pan-American Medical Congress, 1893.

sweating producing copious miliary eruption, we might with justice call it the "miliary fever." In fact, the recent epidemic has by turns exhibited the characteristics of the various disorders described and preserved to us in the writings of several ancient observers, and it may prove of some value to contrast these characteristics with those extant observations.

The following shows what symptoms and conditions were common to all the above-mentioned diseases:

They were all—

Epidemic.

Sudden in onset.

Commenced with chilliness or rigor.

Accompanied by more or less intense headache and fever.

The strong were attacked rather than the weak.

The comfortable classes rather than the extreme poor.

All were attended by sweat of unpleasant or fetid odor.

Occasional varied hemorrhages in all.

Vomiting or purging at times in all.

Meningeal and other nervous symptoms.

Nervous prostration and prickling pains.

Sudden paralysis, heart excitation, heart failure.

Rheumatic pains—gout symptoms.

All were infectious or contagious.

All had catarrhal symptoms, and sudamina or other eruptions of a miliary character.

In all the atmospheric conditions favoring spread of the disorder were fogs and humid atmosphere.

Stimulants were in all beneficial.

All had heart complications.

Sudden excessive secretion of urine and sweating came together.

All were alike sensitive to cold and draughts.

Checked perspiration caused diarrhœa.

Relapses were frequent.

Mortality light in acute influenza, heavy in all others (this can be somewhat accounted for by modern therapeutics and hygiene), and much in this respect depends upon the pecularity of the epidemic.

The sequelæ in all were very similar; the general constitution was shaken—dropsy, consumption, heart failure, low forms of fever followed, and insanity and suicide were frequent.

A brief study of these data will show how very analogous, to say the least, were all these diseases. Certain marked peculiarities not found in other diseases generally, were common to all. The most marked is sweating, so that from the descriptions which have come down to us one could see little reason why the name of "sweating sickness" might not have been applied to any of them (at least in some of their extreme and varied manifestations). The group of nervous symptoms common to all is very striking and peculiar. These diseases seem to have been all recognized as contagious or infectious, and occurred as epidemics, and often seemed to supplant (follow or succeed) one another rapidly. The rheumatoid and gouty symptoms, the heart complications, while in some more prominent, existed in all. The description of the cardiac disease might be applied, line for line, to some of the severer cardiac influenzal cases recently met with, and at times associated with these was sweating, as profuse and overwhelming as that described in the "sweating sickness" of antiquity—lacking only its extreme malignancy.

The sequelæ seem to closely resemble each other in all, and the atmospheric conditions, fogs and rain, and a warm, moist, wet state of weather seem to have in all been exciting causes.

We are almost forced to the conclusion that if not identically the same, these diseases belong to the same group or family, and are intimately correlated. They seem to have preceded, replaced, or followed each other in close succession through quite an extended period, or prevailed in different countries almost simultaneously, at times seeming to be conveyed by contagion or infection. Of their real origin we have no more accurate knowledge today than our forefathers had, but it seems a reasonable and probable deduction that there exists almost constantly in the world a form of influenza (general transient and mild) known to us as the cold we "catch" under various atmospheric causes, which under vicious atmospheric conditions and climatic variations is capable of developing in one or another direction—and so into the various forms which we have been considering. If not all the same in origin, when once their microbic cause is really isolated and identified beyond a doubt, it

will, in all probability be found to be but varying forms and outgrowths of the same germ, or that varying germs exist (as in other cases is already recognized) of similar influence, causing those different diseases which may be considered as but malignant varieties of that influenza with which the world is at present so unpleasantly familiar.

### EPIDEMIC OF INFLUENZA AS OBSERVED IN PHILADELPHIA DURING THE PRESENT YEAR (1893–1894).

During the years of influenzal epidemic disease since its appearance in 1889, its variations in intensity may be summed up roughly as follows:

1889–90, very severe and fatal.
1890–91, mild.
1891–92, marked severity.
1892–93, mild.
1893–94, very marked, but not so widespread and fatal as in 1889–90.

From this it will be seen that every other year it has been severe. The two winters when it assumed a milder form were of the five the most severe in temperature, 1890–91 having an early cold December which seemed to throw its epidemic outbreak toward the spring; 1892–93 being continuously cold, the epidemic outbreak seeming to be worse when favored by a mild fall and early winter and great and frequent changes. This past winter the outbreak began somewhat early, about the middle of December, the usual number of isolated cases having occurred through the autumn. A certain amount of the year's outbreak seemed due to visitors returning from Chicago, where it prevailed in a mild form.

The pulmonary attacks seemed milder, though grip lung was not infrequent. The expectoration was more inclined to be purulent. Even among the aged the fatality was light; one of the authors encountered seventeen cases with one death, and that in a case complicated with pleurisy and effusion and catarrhal nephritis. Of the sixteen recoveries, some of the ages were eighty-six, eighty-two, seventy-eight, seventy-four, sixty-eight, and sixty-four years. The constitutional symptoms did not end by crisis, but continued some time after the local symptoms had subsided.

Diseases other than influenza have shown less of the influenzal stamp than in previous winters, but the traces of the epidemic were still visible when looked for. Considerable vertigo, alternate creeps and sweats, rheumatic pains in the limbs, insomnia, and occipital headache accompanied disorders where such symptoms are not ordinarily met. Temperature ranged lower on the whole than in past years. In bowel catarrhs much colitis (with gelatinous froth, with or without blood) was frequent.

The vertigo was sometimes transient but often very persistent; change of posture induced it—throwing back the head, looking to right or left—sometimes such movements of the head even produced insensibility. This vertigo was often persistent; in one case for a year, being worse on exposure to cold, and finally disappeared with an attack of pulmonary catarrh.

Many cases of stiffness and pain in the back of the neck occurred during this winter's epidemic, some with considerable fever. Constipation occurred in almost all prolonged cases of influenza, was obstinate and marked peculiarly by a tendency to "throbbing in the bowels." This constipation was not due to hardened feces or scanty mucous secretion, but rather to an imperfect power in the muscles of the bowels, the expulsive mechanism, or both.

During the mild weather of the winter catarrhal diarrhœas were more common, associated often with vomiting, which was an unusually frequent symptom during the entire season while during the cold spells pneumonia was most frequent.

As a typical instance of the chronic cases of influenza of the mild nervous variety we might give the following, very recently met with:

A. B., travelling salesman, has had the following symptoms for three years since an acute attack of influenza. He has tickling chilliness of the legs, followed by a cold clammy perspiration on exposure to draughts and cold, and at times when in bed; insomnia or disturbed dreaming sleep, especially in the morning. When awake he is very despondent and irritable; hands numb at night; tinnitus; rheumatoid pain; varying soreness of the eye-balls and abdomen, and a catarrhal dyspepsia.

Temperature 97° to 98°, A. M., and 99° to 99.5°, P. M. He feels much better toward night. Such cases only require excessive fatigue or depressing emotions

or great exposure to produce some of the severer phases of the malady meningeal, pulmonary, cardiac, gastric, intestinal, renal, etc.

*Treatment.*—In the treatment of influenza some changes have occurred. Some progress must be made in the management of a disease so long and constantly present with us. Not only do our necessities lead us to employ new measures, but diseases themselves change, and influenza is not an exception to this rule. If any general and marked change in the behavior of the disease has occurred it has been in the manifestation of a greater susceptibility on its part to the action of old remedies and time-honored measures. In fact, there has been a revival of a number of old-time remedies which have been for a score of years discarded as useless, and which now in our epidemic experience lead us to conjecture that our predecessors were not such fools as we supposed.

New remedies, too, which were unknown to the world in its older epidemics of influenza have been used with advantage, but in general the tendency has been to treat influenza and its sequelæ on the old lines of treatment, and with far more success than in the years since 1889, and we think that this tendency has gradually increased since that year.

For acute influenza, the salicylates and salicin still hold their popularity, which only increases with time and use, especially since we have in the market the pure salicylates of Merck and others, which certainly do not depress the system as did the crude article formerly used; phenacetin combined with these still holds its popularity in early stages, while for the cough in the bronchial form, codeine is more and more used in small doses.

For the marked initial chill, spirit æth. nit. with spirit æth. comp. and chloric ether afford a valuable aid, and when these fail to arrest the often convulsive movements and restore the overwhelmed centres, amyl nitrite and nitroglycerin have often proved successful. Opium in the form of onset accompanied by severe pain has given far better results than in former years, with apparently no bad effects; terebene, turpentine, oil of sandal, and oil of cubebs, as expectorants, and ammonium chloride in the later stages have been relied on; but for the persistent tickling, pharyngeal, laryngeal and tracheal cough, all remedies administered have often failed, but immediate success has been met with by employing a spray of liquid albolene and menthol, five grains to the ounce or more.

Where the grip lung with its psuedopneumonic physical signs made its appearance, counter irritation by mustard has seemed best. The pleurises, by the way, which have been encountered this winter were almost invariably plastic and subsided readily on counter irritation and salicylates.

The purely gastric influenza was treated by cocaine, gr. ¼ in ʒij of aq. chloroformi, as frequently as every hour, while the diarrhœal form was managed readily in most cases by bismuth and opium, cocaine being added where vomiting continued, and in the obstinate cases, and in fact in all the cases which seemed severe at the onset; the bowels were daily flushed out with a one per cent. solution of creolin or boric acid. The effect of this was often marvellous, especially in cases attended by high fever, where the subsidence of temperature was almost immediate.

For the resulting prostration and loss of appetite, full doses, ʒij of bitter tinctures, as cinchona comp., cardamom comp., calumba and gentian, with full doses of strychnine were given; sometimes caffein was added. Alcohol, cod liver oil, hypophosphites, iron, and malt still hold their own, and seem the best known agents for the repair of wrecked and ruined constitutions. Opium has been found to be the most useful drug for the meningeal irritation, or mild or threatened meningitis. Vini iodinii comp., suggested by Dr. Potsdamer, has proved of great service in the chronic cases of all forms of influenza. As to the treatment of the profuse and protracted sweating, we might as well say that after trying all recommended remedies, all equally failed of satisfactory results. Fair trial has been made of the following remedies; atropine and belladonna, quinine and sulphuric and camphoric acids, agaracine, picrotoxine and ergot; small doses of jaborandi seemed to do a little good; also alcohol in moderate quantities; also sage tea and boneset. Externally, alcohol and alum were of some use; internally alum failed. The power of the vasomotor nerves seemed often so impaired that remedies had little or no effect.

# SOME OBSERVATIONS ON INFLUENZAL NEURITIS.*

EDWARD W. WATSON, M. D., PHILADELPHIA.

The field of influenza is almost inexhaustible. Some portions of it have received far more attention than others. If any part can be said to have been neglected it seems to be that of neuritis, in which we have often the most notable failures, and in which also there possibly lies concealed the secret of its pathology and the clue to its mystery.

The different nerve affections of this disease might, if we chose, be divided into three main divisions—general nerve irritation, local functional disturbances, and local neuritis. We might consider the general aching and pain which marks the onset as the first. Functional neuroses may be met with at any period of an attack, but localized neuritis are rather sequelæ than early symptoms.

Now, the main question at issue is, whether in a localized neuritis the peculiar process gains special access to the separate nerves, or even to the nervous system generally; or whether in all influenza, as shown by its initial symptoms, the nervous system is always the seat of such process, though in so benign a degree as to escape notice; or, as a third view, whether while the nervous system is always invaded the nerves of organic life are not generally the principal sufferers, and those of voluntary motion are least and so escape notice.

We should premise that influenza, even in its acute epidemic form, is in all probability a much longer disease than is generally supposed. Early recoveries from pulmonary and abdominal forms are such only in seeming, as shown by the lingering character of the recovery, and the long period during which tonics and stimulants often fail to overcome the exhaustion and inertia. Further, in general, when recovery from acute disease sets in, the whole world brightens to the convalescent, sleep restores, food nourishes, and tonics tone; but after acute influenza there is a long period of semi-recovery—a lethargy of the system in which remedies fail to act.

Now, if in such a case of supposed convalescence exertion, exposure, anxiety are endured, we have, if early in the case, a so-called relapse or more properly a recurrence in some new organ or structure, generally internal; but if later in the convalescence, we are more likely to have an external peripheral neuritis. A central neuritis may at times occur, as in the unfortunately frequent heart failures; but more commonly if walking has been excessive we find a sciatica, or an extension of the disease in the line of the sciatic to the calf, heel, or toe. Where the arms have been overstrained in gymnastics, reaching, lifting, driving, we find a brachial neuritis—generally descending from the shoulder. These attacks should be discriminated from those muscular pains which appear much earlier in muscles in the neighborhood of organs affected by influenzal catarrhs, as the trifacial in coryza, the region of the neck in catarrhal pharyngitis, lumbar pains in renal catarrh, epigastric pain after gastritis, etc.

Of the external neurites the brachial is the most common. This occurred in nearly one-half of our cases; then in order of frequency came the intercostal, sciatic, epigastric, cervical, lower abdominal. The onset of the brachial attack is generally sudden, and often at the first the disease seems reluctant to locate, the pains radiating in the neck and thorax, axilla, and down the arm; soon, however, the painful point will be found quite fixed on the anterior aspect of the head of the humerus (shoulder). Associated with the pain come numbness and tingling in the course of the nerve, and the shifting character of the numbness, etc., from radial to ulnar distribution, or *vice versa*, shows how intermittent is the obstruction and interference with the nerve current (action). These shifting sensations are by no means to be taken as indicating that the active process has extended to the fingers, but that where located it obstructs or interferes with certain nerve fibres distributed to the fingers.

The actual discernible alternation in the course of the nerve is found most frequently in the region of the biceps, though painful points can at times be made out at and below the elbow. The biceps, however, most frequently in protracted cases

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hardens with a doughy hardness and enlarges. In unfavorable cases it afterward wastes very considerably. Similar wasting has been observed in other regions where other nerves are in like manner affected. We are inclined to believe that if proper care be early taken the condition tends to somewhat rapid recovery, but when the arm is used to any extent, and where with this there exists a gouty history or a gouty inheritance, under undue effort, and imperfect nerve-supply, the muscles go into a state of tonic spasm or contraction and the nerve exhausted in its efforts to transmit the force demanded becomes locally still more involved; rarely an eruption of shingles occurs in the course of the affected nerves.

We may as well admit that this condition is somewhat beyond direct and positive therapeutic aid; how serious the condition of the nerve may at times become has been of late shown by careful post-mortem examination. How very hopeless the restoration of function may be, is shown in the series of cases reported by Dr. Ferguson, of Toronto, in the *Medical News* of January 6th of this year (1894), for although no mention is made by him of the fact that his cases were any of them of influenzal origin, though he mentions in one case that influenza had preceded, we think that at least three of the five bear evident marks of being due to that cause. Again, a study of the behavior of these diseased nerves under certain circumstances, tends to throw a partial light into the general gloom. Again and again after applying the interrupted current the pain has been rapidly relieved, but within a few hours a more violent attack has occurred in a more important (and serious) locality—from the arm to the lumbar spine, to the cervical region, to the precordial region, to the other arm; sometimes exhaustion and faintness; sometimes intermittent pulse has been noticed. The same experience has been encountered in the employment of massage of the affected arm, while in other cases in later stages, or in the same case later in its course, both agents have been of the greatest service and conduced to permanent recovery. In three cases long localized pain in the epigastric and abdominal regions has yielded at once and permanently to one short application of the battery.

It would be well also to notice those cases of intra-thoracic and intra-abdominal neuritis attended with much more threatening symptoms, where change of position leads to failure of pulse and loss of consciousness, or to profound nausea, or to respiratory failure, which as they gradually recover seem to do so by an exodus of the morbid condition from within to without; where an emerging neuritis of arm or leg seems the surest harbinger of escape from a fatal illness. The influenzal process seeming to traverse deep-seated and vitally important centers and nerve trunks and emerge to those of less vital moment. This has been a somewhat common termination of many cases of apparent neurasthenia, which should, however, be discriminated from the neurasthenia with which we have of late years—before the influenza epidemic—become so unfortunately familiar, for between them there lies a great difference. In either case the patient is neurasthenic, but has arrived at that condition by quite a different road. The typical neurasthenic has exhausted centers, and we believe may have injured nerve trunks even, by excessive and prolonged exertion or sudden overstrain. The influenzal neurasthenic has the nerve centers, perhaps the communicating nerve trunks, certainly occupied and rendered useless for a longer or shorter time by a progressing disease. In the former case it is but necessary to accummulate force and cause its conveyance to mechanism which we put in the best possible order; while in the latter case we must await the disappearance of the disease before we can hope for improvement; this, we think, supplies the reason for the behavior of the patient under massage and electricity.

In summing up therapeutic results, we can say that rest is an absolute necessity; that electricity has benefited many cases, generally ones of long standing, but has injured, at least for a time, many early cases; and that massage, though less powerful for good, has been only less powerful for evil; while counter-irritation has been disappointing, and repeated blistering has repeatedly failed.

In the early days of the attack heat has been often valuable, where the whole limb could be enveloped in moist heat as by formentation, or swathed in hot flannels, or placed in hot water. But no drug has given reliable results. When improvement has been most pronounced, then re-

lapse and disappointment have been most certain. If to this sweeping statement there be any exception, it is in favor of arsenic in very small doses frequently repeated. Of general systemic treatment, such as strychnine and phosphorus, quinine and alcohol, and cod-liver oil, we are not speaking—these may generally benefit the patient, appetite may increase with assimilation, strength and the general appearance of health may return, but the arm or leg be much the same. Mercuric bichloride, iodides, and bromides have given no results; salicylates and salicin have failed to relieve—they may have prevented. Morphine pushed continuously has seemed to shorten the attack in many cases if given early, possibly by enforcing that rest which is so vitally important to cure; atropine, which controls some of the manifestations of nerve disorder, as the chilliness, excessive sweating, and the pulmonary conditions, is a failure in the neuritis under consideration. Hypodermatics of atropine in the painful points or into the affected muscles (biceps itself) have given no good results. Locally, belladonna, menthol, ichthyol, and mercurial ointment have been used with apparent benefit. But viewed in the most cheerful light treatment is unsatisfactory, and prevention is better than cure. Prevention—if the ideas expressed in this paper are correct—by early and continuous rest continued long enough to allow the system to react and the disease to naturally terminate; and when exercise is permitted, with such restrictions as to avoid tire, general or local, and this will require such confidence on the part of the patient, and such an education on his or her part also, that it will, I fear, be long before the disease is banished by preventive measures.

The treatment of an internal neuritis of a nerve supplying a vital organ resolves itself into a treatment, so far as possible, of the organ involved. To take one case as an illustration—the stomach. All are familiar with the fact that digestive difficulties have been unusually frequent of late; they have taken the form of delayed digestion, with emesis, pyrosis, and eructations. In the majority of these we have found the difficulty to culminate at night, to be least in the early morning. All of them if carefully questioned will give a history of influenza as a starting-point, generally influenza of the gastric form, though perhaps not recognized as such by the patient; they go back to an attack of chilliness and fever with vomiting, fever with loss of appetite, fever with diarrhœa. Following these there will often be a history of gastric pains excited by food; often a distinct account of a peculiar pain or mild gastric pang coming on at short intervals after eating, and peculiar in that it starts in the region of the pylorus and travels in a wave or thrill in the direction of the greater curvature from right to left, dying out gradually as it travels, only to be followed by a succession of such pains. As these pains diminish with days and weeks the patient discovers that he has dyspepsia, and if appetite returns he begins soon to suffer after meals in a different way with acute indigestion. After a time the gastric soreness is almost continuous, and nights and days are passed in great distress, and speedily weakness and emaciation occur. Now, these cases seem to be due, judging by analogy, to a condition of the pneumogastric or splanchnics similar to what we have been noticing in external nerves a long-continued state of diminished action of the gastric muscles, owing to their supplying nerves having been occluded or interfered with by influenzal disease.

Those who have attempted to relieve these cases (which show no evidences of dilatation and rarely of any gastric catarrh) will bear witness to the general uselessness of the old lines of treatment and the new ones as well. They resemble cases of dilated stomach with pyloric obstruction, but are most probably atonic stomachs with normal pylori, in which the force of contraction is insufficient to expel the digested food, or where the almost unknown nervous mechanism of the pylorus is in some way at fault.

When this condition has become aggravated and distress is constant washing out the stomach will undoubtedly give relief, but acids, alkalies and bitters, pepsin and peptonized foods avail little. From careful observation of the general condition, the observer must be led to conclude that a defective innervation and consequent painful and feeble action of the stomach is the real difficulty, and that the retention of food too long leads to the formation of digestive products toxic to the economy and irritant to the organ itself. Intense irritability is often shown by emesis where

the matter ejected seems quite normal; faulty innervation by the cases when digestion can go on normally for days in the recumbent position, but where the patient on assuming the upright or sitting posture invariably vomits after a definite period of time—half an hour or an hour. That increased irritability is one cause of the delay and distress is shown by the character of the only drugs which seem to afford relief. Chloroform, cocaine, bismuth, alcohol and the bromides—these, especially the latter, will in many cases restore appetite, relieve distress, and banish indigestion; but when they fail we seem left with but one alternative other than washing out the stomach, viz., to give the organ as long and continuous a rest in the twenty-four hours as is possible, in order that it may store up power enough and free itself. This gives immediate relief and so is willingly pursued by the patient.

As a formulated plan of treatment, it is best to begin with twenty-four hours of semi-starvation, interdicting all food except a gill of hot milk three times in the first day; on the next day ordinary diet can be given in full amount at the morning and noon meals, but after 2 P. M. nothing until the next morning at breakfast. In a few days the appetite will accommodate itself to the circumstances. The stomach relieved and free from pain does its work in better time and manner, and emaciation ceases and weight is rapidly regained. The weight of the patient should be carefully taken at intervals of three days, and when there is no more increase, where further increase of weight is desirable, then more food must be given; and first a return to some form of evening meal should be tried. Milk or a farinaceous food with milk is best borne, and if all is well the patient can return to his former habits in regard to eating and is cured. If, however, as is often the case, this cannot be done, the extra food may be given in the forenoon—*i. e.*, breakfast at 7 A. M. or earlier; lunch at 11 A. M.; dinner at 2 P. M.; in this way as much food can be taken as ever but without distress.

When from the beginning the distress has been absent at night and severe during the day—as, for instance, where the most serious suffering is experienced after breakfast—breakfast itself must be omitted or reduced to a cup of milk, while dinner and supper are taken as usual, the necessity being for some period of rest continuously in the twenty-four hours of from fourteen to sixteen hours. The lighter cases, where the mid-day meal alone is followed by indigestion, can generally be reached by bromides and a bitter, or by omitting the mid-day meal altogether, even adding additional food at bedtime if the scales show no gain.

How successful this plan of treatment is, how much relief it affords, and how notably the patients gain in weight and spirits, will be realized by anyone who will try it. Crude enforced starvation has always been one of the main remedies of empirics and charlatans in dealing with indigestion, but in the method we have described we believe it to be scientific and valuable.

Cases illustrating the success of this plan, which for the want of a better name we might term "digestive rest," could be given in considerable numbers were it desirable to add to the length of this paper; let it be sufficient to say that in genuine post-influenzal dyspepsia, the writer has met with very few failures save where undoubtedly the directions were not followed. Where the case is severe and the patient can be induced to give the plan a three-days trial, his own relief will be a sufficient inducement to pursue it as long as is necessary.

Rest, then, of all remedies seems most fitted for the relief of influenza from its onset to its remotest sequel. There seems always to be a deficiency somewhere or other in the power of sustaining voluntary and involuntary exertion, and a tendency to aggravation or relapse on exhaustion. Did time permit, a study might be made from this point of view of other post-influenzal conditions, showing for instance how the peculiar catarrh of the liver is best treated by relieving the liver of work, in the shape of foods it cannot manage and of cholagogues it cannot endure; how the influenzal affection of the ocular muscles, which baffles the best-meant efforts of relief with lenses, yields speedily to darkness and disuse of vision; and lastly, how the mania and delusions of influenza are combated most hopefully by those remedies and means which, like opium, enforce sleep continuously for considerable periods of time.

# BACTERIOLOGICAL NOTES.

## THE RELATION OF BACILLUS COLI COMMUNIS TO TYPHOID FEVER.

In a paper presented to the American Public Health Association in Mexico, December, 1893, (*Modern Medicine*, III, 1894, p. 4), Kellogg gives a brief summary of recent investigations concerning the etiology of the colon bacillus after which some personal experiments are related.

It will be remembered that in 1887 Hueppe called attention to the possible pathological importance of the colon bacillus, having found this organism in nearly pure cultures in cases of cholerine. In 1889 Roded and Roux made extensive investigations of this bacillus in relation to typhoid fever in which the conclusion was reached that the typhoid germ is a modified colon bacillus. Several investigations have been recorded of outbreaks of typhoid fever resulting from the use of the water from a common source, usually a well, from which no typhoid bacillus could be found, but the colon bacteria were present in large numbers.

The claim that is made at present by certain bacteriologists is that the colon bacillus which ordinarily possesses very little pathogenic power can be made sufficiently virulent to produce an effect similar to that of the Eberth or typhoid bacillus.

Another interesting fact is the observation that the colon bacillus becomes increased in virulence during an attack of typhoid fever.

Vallet has shown that rabbits that were inoculated with the filtrate from vaults containing excreta from typhoid fever patients were protected to an appreciable degree against the inoculation of the typhoid bacillus. This experiment serves to explain the fact so often noted by sanitarians, that visitors to an infected locality are more likely to suffer from the disease than the residents who are accustomed to drink the contaminated water.

After certain experiments which are too lengthy to record in full, Kellogg draws the following interesting conclusions based upon his own work and the results of other investigations:

1. The bacillus coli and the bacillus of Eberth are so nearly identical in their biological characters that none of the numerous methods proposed for distinguishing them can be relied upon as giving constant results.

2. The bacillus coli gives in inoculation experiments identical pathological effects with those produced by the bacillus of Eberth.

3. The bacillus coli acquires, by passing through the body of an animal, biological characters closely resembling those of Eberth's bacillus. The bacillus coli found in vaults is much more virulent than the bacillus coli of the intestines or Eberth's bacillus.

4. The bacillus coli is much more resistant than the bacillus of Eberth, and thrives in vaults, while the bacillus of Eberth quickly dies under the same conditions.

5. The study of epidemics, and the bacteriological study of waters which have given rise to typhoid fever, lead to the conclusions that the bacillus coli at least shares with the bacillus of Eberth the property of producing typhoid fever under certain circumstances, and that the bacillus of Eberth may be only a variety or modified form of bacillus coli.

6. The contaminations of milk with the excreta of cows is a possible source of infection with the bacillus coli and with typhoid fever.

7. The same care ought to be observed in the protection of water used by cows kept for milking purposes from contamination with excreta, as for that used by human beings for drinking purposes.

8. Since vaults and cesspools constitute depots in which the comparatively innocuous bacillus coli acquires malignancy and virulence, rendering it highly destructive to human life, these convenient nuisances should be prohibited by law, and the destruction or disinfection by proper agents, or conveyance to a safe distance from human habitation, of all alvine discharges, should be compulsory as one of the most important means of conserving the public health."

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UNKIND words can never be taken back.

## THE FLAGELLA ON THE TYPHOID AND COLON BACTERIA.

Moore (*Wilder Quarter-Century Book*, 1893) has described the molite appendages or flagella on three species of bacteria, viz., the bacillus of hog cholera, of typhoid fever and bacillus coli communis. A brief review of the literature on the method of demonstrating flagella on bacteria is given together with the author's modification of Loeffler's method. The flagella are carefully described. The point of special interest is the close resemblance that is found between the flagella of the three species but, perhaps, more particularly between the typhoid and colon bacteria.

The flagella are minute hair like appendages which radiate from the body of the bacillus. They vary in length and number. On the typhoid germs ten of these filaments was the maxium number found and on the colon bacillus seven was the greatest number. These varied in length from one to thirteen *microns* on the typhoid and from one to fifteen *microns* on the colon bacillus. They were from 0.1 to 0.2 *microns* in diameter when well stained.

These results differ from those obtained by Luksch, who found from 8 to 12 flagella on its typhoid bacillus and from 1 to 3 on the colon bacillus, a difference sufficiently great to be of differential value. Moore's results show that it is very difficult, if not impossible, to distinguish between these two species of bacteria by means of their flagella.

His conclusion is of considerable importance in showing that morphologically it is difficult to distinguish between these bacteria. It also shows the importance of the cultural characters of these bacteria in differentiating between them. In studying the flagella, the author endeavored to determine whether there was a difference in the flagella to correspond with the difference in the virulence or cultural characters of these bacteria, as they are often found to vary in these respects, when isolated from their apparently normal habitat. The conclusion reached was that there is no difference in the flagella to correspond with their functional variations. The author touches indirectly the question of fixing specific characters of bacteria or their functions. In these two species, for example, there is no doubt as to their specific differences, yet morphologically they are hardly distinguishable, but in their cultural or physiological properties they are easily differentiated. The little that is known about the structure of bacteria suggests the possibility that there are as yet unknown structural difference between bacteria which exhibit differences in their cultural or etiological properties.

## THE RELATIONS OF BACILLUS COLI COMMUNIS TO APPENDICITIS.

In the *New York Medical Journal* for December 30, 1893, Hodenpyl, has contributed an exceedingly interesting article on the etiology of appendicitis. The author summarizes the results of the bacteriological examinations of twenty-four cases of appendicitis and adds the results of many others. Of the thirty-five cases of which a bacteriological examination has been made the *B. coli communis* was the only germ isolated in thirty-two of them. In some cases colonies of these germs were found in the walls of the appendix. In one case a few colonies of the streptococcus developed in association with the bacillus. In one case the streptococcus were the only species of bacteria found. The streptococci found correspond in their biological characters with S. pyogenes. In one case *bacillus pyogenes foetidus* was found in addition to the colon bacillus.

Cultivations have been made from the contents of the intestinal tract and from the contents of several healthy appendices. In nearly every case *B. coli communis* appeared and frequently pure culture. In ten cases cultures were made from the peritoneum surrounding the appendix in people that died from different causes. Nine of them gave negative results.

The pathogenic power of *bacillus coli communis* is determined in two ways: (*a*) its occurrence in connection with lesions

unassociated with any other organism; and (*b*) the result of experiments on animals with this pure culture of the germs. It has been found presumably as the etiological factor in a large number of diseases. Among those may be mentioned general exudative peritonitis following perforation of the intestine, perirectal abscess, ulcerative colitis, suppurative inflammation of the gall-bladder, peritonitis following ulceration of the intestine without perforation, epidemic diarrhœa of children, endocarditis, meningitis, cystitis, arthritis and many other affections.

From his study of the colon bacillus and the results of other investigators, the author concludes this part of his paper with the following recapitulation:

1. "*Bacillus coli communis* is normally present in the intestinal canal after birth, but it is never found during life outside the intestinal canal in any of the other viscera, so far as is known, without being accompanied by lesions."

2. *Bacillus coli communis* has been found in the exudate in thirty-four out of thirty-five cases of exudative appendicitis, and in thirty-one of these it was found unassociated with other bacteria.

3. It has been found in connection with a variety of inflammatory and necrotic conditions other than appendicitis.

4. "Inoculations into animals of pure cultures of this bacillus result in inflammation, in the formations of abscesses, and sometimes produce general septic infection or intoxication."

## HYGIENE AND COSMETICS.

Hygiene is a science of modern times. It has grown from small beginnings until at present it is the most important part of a physician's study. The aim of hygiene is to find out the most favorable conditions of human life, as well as the means of preventing disease. If we speak of the hygiene of a single organ or a group of organs, it becomes a matter of determining the conditions under which this organ can attain its most suitable and complete cultivation, so as to be of the greatest use to the entire individual.

By cosmetics we understand those means by which mankind undertakes to make his body, or any of its organs, pleasing to the eye—that is, with the idea of being healthy and strong, on the one hand, and well formed and handsome on the other.

Any cosmetic which helps to improve and beautify an organ without injuring the health is helpful to gygiene. In other cases, however, although the desire to be beautiful is natural, the cosmetics used are injurious. Then the health suffers, and the cosmetic becomes a wicked enemy to hygiene. If one applies himself to a careful and scientific care of the skin, he must employ very important hygienic means. If one makes his head tender by continually wearing a covering which will not allow the air to come through, premature baldness will be the result. If one considers the normally built human foot beautiful and has a covering made reasonably suitable to its shape, he fulfills a very important hygienic condition for good walking. If one considers the pointed shoe handsome and forces his foot into it, this is a cosmetic, but by no means a hygienic measure. Crippled toes and corns are the result. We see, therefore, that hygiene and cosmetics stand in near relationship to each other, and should not be separated. Hygienic measures are dictated by reason; cosmetics by vanity. Naturally those hygienic measures will spread rapidly which serve the purpose of cosmetics, while hygiene is in a bad case when it must combat the temporary cause of injurious cosmetics.—Translated for *Public Opinion* from the German of Karl Rose, in the *Breslau Deutsche Revue.*

**For Chronic Articular Rheumatism.**

℞ Potassii iodidi..... gr. iij.
Potassii bicarbonatis..... gr. xv.
Quininae hydrochloratis..... gr. iij.
Infusi cinchonae acidi ad.....℥j.
Misce et fiat mistura.
Two tablespoonsfuls to be taken three times a day.
—*Practitioner.*

"I DON'T see your husband with you so much as when you were in your honeymoon," said the clergyman, as he meet an occasional attendant at his church. "Has he grown cool?" "Not if what you preach be true," she said, coyly. "He is dead." —*Toledo Blade.*

# THE MEDICAL AND SURGICAL REPORTER

ISSUED EVERY SATURDAY

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SATURDAY, APRIL 7, 1894.


## EDITORIAL.

### THE MEDICAL TREATMENT OF ANARCHISM.

There is a legend, redolent of antiquity, to the effect that a certain apoplectic and irascible citizen, self-made—the job of an apprentice—and of massive self esteem, once found his path occupied by an insignificant dog. Heeding nothing but his own convenience, the self-made, without due ceremony, proceeded to assist the animal to move aside. This injudicious action attracted the attention of the business end of the dog and resulted in a protest more effective than respectful. His dignity violated, the enraged apprentice's job roundly berated the owner for allowing such a vicious beast to be at large, and demanded the extermination forthwith of the dog that had bitten him.

"But," demurred the owner, "the dog is not mad."

"Mad," howled the infuriated egotist, "what in thunder has *he* got to be mad about? It's *me* that is mad."

This fable teaches whatever moral may be extracted from it, but it will serve to illustrate the emotional perturbation which led the *London Hospital* to evolve the following:

"That Anarchists, as a matter of fact are lunatics, is as obvious to common sense as that a dog is mad when he rushes at friends and foes indiscriminately, and with frantic teeth endeavors to tear them to pieces. The point of our question is this: Are European jurists prepared to pronounce Anarchists technically insane, and will Legistures enact statutes for their certification and restraint? The medical mind foresees an epidemic of Anarchism in the near future, and its natural instinct is to look about for preventive measures. The only preventive measures of any avail to avert severe epidemics of contagious diseases in cattle have been the killing of the infected cattle in the very earliest stages of the malady. In the case of human beings, the very early detection of cases and their prompt isolation have alone been efficient. Our first business is to secure the enactment of a statute or statutes declaring Anarchists and in-

citers to Anarchy "insane." When that has been done, competent investigators must be set to work to find out every possible British or foreign Anarchist or inciter to anarchy which our own country may harbor. These must then all be locked up in one or more criminal lunatic asylums, and there medically treated until such as are capable of cure are thoroughly cured; the remainder will be kept under restraint for life."

This suggestion to make, by legislative enactment, anarchism to be a disease and to prescribe a specific course for its treatment, might be regarded as a specimen of insular humor, were it not that the continued and atrocious crimes perpetrated by anarchists have forced a consideration of the subject upon every nation of the civilized world.

There is no doubt that some of these anarchistic outrages are perpetrated by individuals mentally unbalanced—some of them to such a degree as to be, in truth, irresponsible. But to attempt to prevent the spread of anarchism, and to expect finally to eradicate it by the enactment of repressive laws, the enforcement of which would require an inquisition of greater severity and unrighteousness than the Holy Office of barbarous Spain, would be very much like the effort of the old lady to restrain the Atlantic ocean by the vigorous use of her broom.

The proposition to officially declare anarchism to be insanity, and consequently irresponsibility, is not surprising in view of the apparent tendency of modern alienists to consider any variation from a standard assumed as the norm—which standard is remarkably inconstant—to be insanity. Insanity existing there can be no responsibility; the overt acts of irresponsible individuals cannot be held as crimes; the commission of crime is *prima facie* evidence of insanity, and therefore of irresponsibility, for the obvious reason that it necessitated a departure from the standard assumed as the normal. This may appear to be gross exaggeration, but it seems to be the foundation of the present style of reasoning in circles.

Whatever may be the responsibility of individual anarchists, it would be folly to assume that anarchism is *per se*, a degree of mental unsoundness sufficient to eliminate responsibility. Nor does a generalization from the manifestations of anarchism developed of recent years, justify the assumption of irresponsibility. The overt acts of anarchism, responsibility assumed —as it should be, are placed on the level of crime—where they belong, and are amply provided for, so far as punishment is concerned, by existing laws. Furthermore to declare anarchism, whatever that term may mean, to be insanity would ultimately result in reducing all crime to insanity, for anarchism would naturally include everything in opposition to order as it now is.

Anarchism exists. It is a problem that must and will be solved in the course of human development. But it is something more than a disease, physical or mental, and but a small portion of the subject lies within the domain of medical science, or is amenable to medical procedures for treatment.

What is anarachism? Theory, policy or conspiracy. Is it any or all of these?

That oracle of indigestion, Thomas Carlyle, once overheard a conservative Englishman, whose satisfaction with himself and his associations was complete, remark, in a very patronizing way to a more progressive man: "The British people, sir, can afford to laugh at theories." The wrathy philosopher, fixing the speaker with a glare, said, "Sir, the French nobility of a hundred years ago, said they could afford to laugh at theories. Then came a man who wrote a book called the 'Social Contract.' That man was Jean Jacques Rousseau, and his book was a theory and nothing but a theory. The

nobles could laugh at his theory, but their skins went to bind the second edition of his book."

Anarchism is something besides theory, and it would be base flattery to compare it with the French Revolution.

It can scarcely be said to be a policy, for, although claiming the purpose of reforming the present unsatisfactory conditions of life, unlike other reformatory movements which may appear akin to it—Socialism and Communism—it does not aim to provide any substitute for the conditions destroyed, nor to reconstruct any system of living from the materials of the fabric torn down.

Evidently a conspiracy, anarchism would seem to have some of the elements of a policy, and many of the characteristics of a theory.

It would be hard to furnish a definition of the term anarchism that would be at once accurate and comprehensive. It might be said to be total depravity. Perhaps it would be better defined by a provincial expression as pure on'ry fool-cussedness.'

As with the term electricity, we may arrive at the meaning of anarchism by a consideration of its manifestations and conditions. Thus, we find, invariably associated with anarchism, dirt, drink, disorder, degradation and debauchery. Undoubtedly environment is the most potent of predisposing causes, but there are others which are ever present and which relate particularly to the individual. For instance, that congenital or acquired 'constitutional tiredness,' which incapacitates the individual for effort; again a keen recognition of the desirability of utter abnegation—on the part of others; a sense of the injustice of urging the rights of any as against one's own, and other like conditions familiar to all. Among the exciting causes might be mentioned the cumulative effect of intoxicants; the exhaustion of credit at the bar of greedy capital; the unwarranted interference with individual desires or demands by the servile minions of a bloated plutocracy, acting by authority of unjust laws, whose evil design is to subordinate the individual's rights to those of the masses. In a word any failure on the part of creation to bring itself instantly into harmony with the present mood of the individual. Anarchism is a vicious kick against existence.

However conflex its nature, and however varied its manifestations, anarchism exists; will exist so long as do its causes; and will grow in direct proportion to the intensity of the conditions producing it. Neither direct repressive legislation, nor the construction of asylums to prevent its spread, or to accomplish its extinction, nor international measures for mutual protection, nor any agencies, physical or mental, will accomplish more than temporary mitigation of the evil so long as its causes persist unchanged.

Anarchism is an anomolous bye-product of civilization. It is an expression of natural law. It may be regarded as a retrograde metamorphosis. It is the desperate protest the less-fit against the extinction rendered inevitable by environments with which they are hopelessly out of harmony and which are surely if slowly accomplishing their destruction.

Anarchy finds its material in that class of humanity where the powers of resistance and insistance have failed to meet the demands made by the swiftly developing changes of modern civilization. Civilization itself, rather than the unfortunates who suffer because of inherent weakness, is responsible in large measure for the existence of the unhappy conditions, and it is within the power of the popular will to eliminate them. Merely to mention a few of the admitted causes of anarchism, which can be, and eventually must be changed, consider these facts. Mankind is fully aware that the progress of civilization is due to and depends upon the in-

crease of mental and moral power, which in turn, depends upon the increase in nerve power to resist the increase of pressure from environment, or a loss of balance would result which would be anarchy. And yet in place of making every effort to strengthen the nerve centres they are deliberately weakened by allowing and even encouraging the use and abuse of artificial stimulants, of unhealthy excitements, and of lethal narcotics. With accurate knowledge of the terribly evil consequences of concentrating individuals into very limited areas, the populations of great cities are allowed to grow denser and denser, until in the slums it is no uncommon thing to find a 10x12 cellar or attic furnishing a residence for two or three families of eight to fifteen individuals. Again the relations of capital and labor, and other similar problems of social and political economy. And under and pervading all, "Man's inhumanity to man."

Subject to the violent and unequal fluctuations of such stresses, human nature is to be developed, and there is little wonder for the existence and growth of that class of humanity among whom anarchism finds most favorable conditions for rapid and rank development. That expression of human nature which we term character, is a combination of the emotional, intellectual and moral elements of man. The emotional and intellectual phases are under the immediate direction of the will, as indeed is the moral element to a large extent. But the peculiar office of the spiritual is to inform and counsel in the exercise of the will power. The spiritual element of character, the most intangible, the most sensitive and yet the most important of man's nature, is the most difficult to maintain, and is the first to give way to inordinate stress. A marked feature of degeneracy is the lack of the sense of right and wrong—'moral imbecility' as it has been termed. From hence the descent to Avernus is easy.

With the constant and increasing output of defective classes, we are presented with the unique spectacle of society establishing and fostering products bound to act for the extermination of social order, and in place of preventing such products by destroying the services of production, wagging the head and seriously considering measures for eliminating its own workmanship. There is no need of wasting cerebral energy to discover some method by which one can both eat his cake and have it.

There is a remedy, a specific not only for the prevention, but for the cure of the evil; a remedy that has been known and proved for centuries. It is simple—so simple indeed, as to be quite overlooked by modern magicians and soothsayers. It requires no legislation to make it applicable; it does not infringe upon the rights of the individual nor of the public; it merely requires the actual practice of what is professed by the vast majority of anarchy producing nations. This remedy is the *spirit* of Christianity, with especial emphasis placed on that manifestation embodied in the two social laws: "Thou shalt love thy neighbor as thyself," and, "Whatsoever ye would that men should do to you, do ye even so to them." At once the simplest and most efficient, it is the only solution of the problem.

Until such time as this remedy will commend itself to the wise and prudent, all sorts of methods of treatment will be invented and experimented with, and fail.

Since anarchism has reached such proportions that it has become a matter of international consultation, we would respectfully suggest a plan that would seem to have some valuable features. It would certainly save expense in the long run; it would relieve the world of the feeling of terror that is now so widespread; and it would afford an opportunity to propagandists to demonstrate the righteousness of their professions, by means of a gigantic

object lesson which the world could observe without fear, and could study at leisure. Certainly it would be a much easier and quicker way to convince doubters and to obtain converts than are the eccentric and explosive arguments now in vogue.

Let the nations pool their issues, and set apart a desirable, but isolated territory, and then deport all adult, confirmed and irrepressable exponents of anarchistic vagaries, of both sexes. Carry them to this reservation and allow them work out their salvation without let or hindrance, the one restriction to absolute freedom being enforced residence in their peculiar locality.

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**"Fracture of the Lower End of the Radius with forward Displacement of the Carpal Fragment."**

*Mr. Editor:*—I shall be greatly obliged if you will inform your readers that I am particularly anxious to know of any cases of Fracture of the Lower End of the Radius with Forward Displacement of the Carpal Fragment. Notes of cases, references to published reports, or information of specimens in museums will be of much interest to me.

Yours truly,

JOHN B. ROBERTS,
1627 Walnut Street, Phila.

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A a meeting of the Philadelphia County Medical Society held March 28th, the following resolutions were adopted:

*Resolved,* That the Philadelphia County Medical Society has heard with great sorrow of the sudden death at Lebanon, in this State, of Dr. John Rauch, of Chicago, late Secretary of the Illinois State Board of Health; a man whose interest in the cause of Medical education and whose efforts in increasing the efficiency of the medical profession and maintaining its dignity and honor have rendered incalculable service to the public.

*Resolved,* That this resolution be published in the Journal of the American Medical Assocation and in the medical journals of Philadelphia.

T. B. SCHNEIDEMAN,
Secretary.

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# ABSTRACTS.

## MEANS OF PREVENTING THE SPREAD OF CONSUMPTION.

### CIRCULAR OF PHILADELPHIA BOARD OF HEALTH.

All cases of tuberculous disease of the lungs (Consumption) taken origin directly or indirectly from other cases. This is now an established fact. Infection, however, is easily provided against if certain simple precautions are taken.

The chief modes of infection are:

First and Foremost—*By inhaling dry and pulverized expectoration.*

This is apt to occur when an ordinary pocket handkerchief is used by a tuberculous person for expectoration. When such a handkerchief is opened the dried expectoration is likely to be pulverized and diffused through the air. Thus it may be inhaled by others as well as by the patient himself, who is likely to suffer from drawing disease germs into portions of lung previously unaffected.

Another, and the most common source of pulverized expectoration, is the habit of spitting carelessly and indiscriminately, as on the floor or ground. The expectoration becomes dried and mixed with dust and then is easily carried into the air, and is breathed into the lungs or swallowed. The habit, therefore, is not merely offensive, but dangerous.

(2). *By using spoons, cups, and other articles* of the kind which have *not* been

*properly washed* after having been used by tuberculous persons.

(3). *By kissing.*

This source of infection is especially to be guarded against in the case of children.

*Self-infection* may occur, in addition to the ways mentioned, *by swallowing the expectoration.* The habit is likely to lead, sooner or latter, to infection of the intestines with tuberculous disease.

There are other modes of infection, as for example, by consuming the flesh and milk of animals having the disease. But this source is less common, and, as prolonged high temperature destroys the germ, if we cook our food (including milk) thoroughly, there will be no risk of becoming infected in this way.

Knowing the channels of infection we can easily take effective *precautions.*

(1). *The sputum must be destroyed and must not be allowed to become dry.* A spitting cup or flask containing just enough disinfectant solution to cover the bottom of the vessel should always be used for the expectoration. Out of doors a pocket spitting flask, such as Dettweiller's, should be employed.

In the house it would be well to use a pasteboard or paper cup, which should set in a china or metallic *holder. This cup with its contents should be burned at least once a day, but if the expectoration is considerable, much oftener.

Pieces of linen or calico about ten (10) inches square may also be carried. These should be used in case of absolute necessity only, and should be burnt as soon as possible afterward. No piece should be used more than once.

(2). Bed-rooms that have been occupied by tuberculous patients *should be thoroughly disinfected* before they are occupied by other persons, and a declaration or assurance on the point should always be demanded.

If the previous occupant of the room never allowed the furniture, hangings, or carpets of the room to be contaminated with the sputum there would be little need of this precaution. But as the people ordinarily of cleanly personal habits sometimes show a surprising amount of ignorance or carelessness in this respect, the following points should be insisted on:

(*a.*) Carpets, curtains and bed coverings should have been exposed to superheated steam under high pressure.

(*b.*) The floor and walls of the room should have been properly disinfected. Rubbing with new bread followed by the application of corrosive sublimate solution (a tablet of 7⅞ grains added to a pint of water) is probably the most effective practical method.

*There is no danger of infection from the mere breath* of a tuberculous patient. *The risk is from the dried expectoration.* Danger of social intercourse arises from the neglect of the precaution described.

Fresh air is of the highest importance for tuberculous persons. Hot and stuffy rooms have an evil influence over the disease. Except in special circumstances the bed-room window should be kept open by night as well as by day.

NOTE.—The disinfection of rooms that have been occupied by the tuberculous patients, and of beds, bedding, curtains, carpets, etc., will be promptly attended to upon a notice sent to the Health Officer, City Hall. The Board of Health has erected a most extensive and complete disinfecting plant for the disinfecting of such articles as have been mentioned, and upon notification will send for them and return them after thorough disinfection at a cost merely nominal.

*Cup and holder can be procured at the apothecaries. The paper cup can be easily made at home from the original sample.

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**Toots from the Ram's Horn.**

PLEASURE may be bought, but happiness never.

STARTING for heaven on a gravestone is risky business.

Habit is first a servant, then a master, then a tyrant.

THE man who succeeds as a hypocrite has to devote his whole time to it.

SOMETIMES a single step in the wrong direction is equal to a mile.

No wound can be so deep as the one inflicted by a friend.

A PRESENT sometimes costs the recipient more than it costs anybody else.

ONE person's opinion is frequently based upon the exploded opinions of others.

A FEATHER from the dove's wing sometimes guides the arrow that pierces her breast.

## CHOLERA AND THE UNSANITARY CONDITION OF HAVRE.

Mr. Adolph Smith, the foreign correspondent, writes to the *Evening Telegraph* as follows:

In the autum of the year 1893 I wrote some letters from Havre describing the cholera epidemic which devastated that town. After Hamburg, of the large towns in Europe, Havre was the town which suffered most from cholera. It was to be hoped that severe lesson would have been turned to some advantage, and that the town would at once proceed to undertake works of a sanitary description. I am sorry to say that as yet nothing has been done; we have had words, and plenty of words, but no action. Chiefly through the instrumentality of M. David, the town architect, an Exhibition, of Hygiene was held at Havre last year. This served as an object lesson for the population, and in that sense was useful, for it showed how houses ought to be drained. Then a great deal of time was lost in making experiments with the Hermite system, but nothing more than discussions and experiments can be recorded. The town remains as unhealthy as it was before. Last year there were some more cases of cholera, and this year a small-pox epidemic is prevailing. The day before yesterday there were six cases of small-pox, and a short time ago there were as many as thirty-three cases of small-pox in a single day. The hospitals are more incumbered now tha they were during the great cholera epidemic; for though there have not been so many cases of small-pox as there were of cholera, the former disease is of much longer duration. A cholera patient often died in a few hours, or was cured in a few day, whereas a small-pox patient takes a month more to cure.

Nothing can be more disheartening than the sanitary condition of some of the streets at Havre. There are houses where it would be absolute murder to send any one to inhabit; yet nothing, it seems, can be done against these death traps. There is one house in particulor where almost every inhabitant dies of consumption. The air is so foul that even the robust soon become predisposed; and, as the whole house is impregnated with the germs of tuberculosis, the inhabitants cannot fail to contact the disease. In due course they die of phthisis, unless some other and more rapid disease sweeps them off beforehand. The Bureau d'Hygiene has rendered a great service in showing up these black spots. The institution has calculated the death-rate per street, and this on an average of ten years. We have before us, therefore, no accidental or exceptional figures, but a normal average, reckoned over a large number of years, and these figure, tell us that the worst street in Havre is the Rue de la Boucherie.

### A TALE OF DEATH.

This—the Butchers' Row—is appropriately named, only it is human beings and not cattle that are butchered. The average mortality of Havre amounts to the enormous figure of 30 9 per 1,000 per annum; but in the Rue de la Boucherie the mortality during the same time was equal to 55 1 per 1,000 per annum. In the ten years there had died out of every thousand inhabitants in this fatal street no less than 551 persons. Thus but for new arrivals the entire population would be swept away in less than twenty years. The same may be said of the Rue Francois-Mazeline, where out of 1,000 inhabitants 503 died in the ten years. The other especially bad streets are the Rue du College, 454; Rue de la Vallee, 454; Rue du Petit-Croissant, 449; and the Rue Albante, 411 deaths per 1,000 inhabitants in ten years. . .

There are besides thirteen streets where from 351 to 392 deaths occurred per 1,000 inhabitants in the ten years. Then we have sixteen streets where the number of deaths varied from 312 to 346 per 1,000 inhabitants in ten years. Finally there are twelve streets where the deaths numbered from 251 to 296 per 1,000 in the ten years. These latter twelve streets bring us down to an annual death rate of 21 1 to 20·6 per 1,000, which being below the average of the entire town, represents healthier quarters. In the Rue des Bouchcries, needless to say poverty, overcrowding, filth, ignorance, drunkenness, and wretchedness of every description, unite to kill off the population. There is especially a large proportion of Breton laborers, whose drunken and filthy habits are notorious. The streets where there is the

highest mortality are very narrow, the houses very high, and many of the rooms are never purified by a direct ray of sunshine. If we add to this the fact that there are no sewers, but all the filth flows into the street gutters, it may readily be imagined that deaths must result.

By the side of the general death-rate we have the death-rate from consumption, and we find that, roughly speaking, the deaths from phthisis are most numerous where the general death-rate is higest. Nevertheless. though this is correct, if we take groups of streets individually, it is the narrowest streets that have suffered most. Thus the Rue des Boucheries has 551 deaths and 81.1 death rates from phthisiss whereas the Rue du Petit-Croissant has 449 deaths and 122·9 death-rate from phthisis; but the former street is 8·67 metres wide and the latter is only 4·95 metres. In other cases, where the narrowness of the street does not seem to correspond so well with the number of deaths from phthisis, it will be found that the houses are expectionally high. Thus the street, though not actually is proportionately narrow. The condition of Havre, therefore, as ably demonstrated by the statisticians of the Bureau d'Hygiene, shows clearly that the want of pure air is one of the main predisposing causes of consumption. Of course this same cause increases the death-rate from other diseases, but it has a very terrrible bearing upon consumption.

## A CASE OF SIMULTANEOUS EXTRA AND INTRA-UTERINE PREGNANCY.

Dr. H. Gulzmiller (*Arch f. Gyn.*, Bd. 43, p. 223), reported the case of a patient, aged thirty-five, who had been pregnant four times, began with fifth pregnancy in May, 1890. As a result of some injury labor pains set in about Christmas, 1890, followed by discharge of blood. During ing Spring of 1891 a new attack of illness, particularly characterized by acute abdominal pains, together with the belief on the part of the patient, that the pregnancy had existed since the last twelve months, induced her to consult a physician. Prof. Courroisier made a diagnosis of extra uterine pregnancy with death of the fetus.

The fetus in the abdomen could be felt on the right side of the uterus. A sound passed into the uterine cavity showed it to be 8 cm. in length. Some days after this examination there was a discharge of blood and an increase of temperature. This rise in temperature was accepted as an indication of decomposition of the fetus; and on June 11, 1891 the operation was performed. A dead fetus of about eight months was found lying in the left tube. There was no decomposition of the amniotic sac. The child and the greater portion of the placenta were removed; the sac was stitched to the abdominal wall. On the following day, June 13, a three months fetus was expelled from the uterus. An uninterrupted recovery followed; all the remains of the placenta in the extra-uterine sac were expelled. A microscopical examination of the sac revealed that it was originally of tubul structure, which had become distended. The abortion of the intra uterine pregnancy was due to the introduction of the sound.

A collection of seventeen cases of simultaneous extra and intra-uterine pregnancy, found in the medical literature, were carefully reported, some of which consisted of twin pregnancy.

In closing the author enters into the careful examination of diagnosis, prognosis and treatment of these cases.—*Translated by M. B. Werner, M. D.*

### Snap Shots.

To be congenial it is by no means necessary that two persons should be alike in their dispositions or tastes.

There is something so imposing about a silent man that we hardly ever reflect that he very probably has nothing to say.

Whether or not a man is reliable depends frequently upon the persons with whom he is dealing.

The flea is the dog's best friend. It keeps him from being lazy and feeling lonesome.—*Florida Times-Union.*

# SOCIETY REPORTS.

## THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

*February 28th, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### DISCUSSION

Of papers o f Drs. Seiler, Curtin, and Watson, (See pages 457 and 490).

DR. JUDSON DALAND: Dr. Curtin's remarks with reference to the sweating sickness were of special interest to me, and one readily understands why the name was applied to this disease in olden times. His descriptions of epidemics that occurred long ago were well made.

Dr. Curtin's wide knowledge and extensive experience make anything that he says in regard to the therapy of this affection of great importance. With regard to the "grip-lung" to which he refers, this affection has for a number of years attracted my attention, particularly from a diagnostic point of view.

The physical signs in these cases often vary from day to day with extra-ordinary rapidity, in fact with such rapidity as to make one doubtful of the correctness of the first diagnosis. The pathological examinations show a mixed condition of bronchitis, catarrhal pneumonia, and collapse. These lesions occurring in different parts of both lungs, and varying with such extra-ordinary rapidity, suggests a distinctive nervous origin, and there is probably an interference with the nerve-supply of the lung.

I did not hear Dr. Curtin mention the use of strychnine and alcohol in the treatment of the general disease. The benefit derived from the use of these agents during the height of the disease is very great, and they are practically the chief remedies to be relied|on. The use of the salicylate of sodium and phenacetine has given me the results which he has mentioned.

Regarding the suggestion of Dr. Seiler that this affection be called American grip, I should say that although I have not studied European grip the descriptions which I have read, and the numerous conversations that I have had with Continental physicians, have failed to convince me of any essential difference in the disease as we see it here. I therefore think it unwise to add another to the various synonyms for influenza, which name the is one to be preferred.

Dr. Seiler also states that the chief cause of death is hemorrhage from the mucous membrane. In my experience the chief cause of death has been the pulmonary complication. With regard to the use of benzoate of sodium, I do not think that the favorable result described could be expected in many cases as seen in general practice.

With regard to the effect of quinine in the production of insanity and other mental disturbance in influenza, although I have seen many cases of influenza, most of which have received quinine, I have yet to see a case in which the causal relation between the mental condition and the use of quinine could be established.

DR. J. SOLIS COHEN being called upon by the President, said: I came here to listen, and have not prepared myself to take part in the discussion. I remember the inital papers of Dr. Glasgow and of Dr. Seiler very well, but while Dr. Glasgow named the disease "it," he distinctly stated that in his reading he could not find anything that resembled it except the old records of influenza. This was a very acute observation, made, as it was, three or four years before the epidemic became pronounced. My own earlier cases were treated exactly as Dr. Glasgow had recommended—that is, with benzoate of sodium, and I do not now know of any treatment that acts better than putting the patient at rest, giving benzoate of sodium in ten-grain doses every hour or few hours until the kidneys are acting freely, and then continuing it less frequently. Strychinine, acting as it does on the terminal nerve fibres, is of great service, for the disease exerts its baneful influence markedly on the terminal nerve fibers of the structures concerned in the nutritory and circulatory systems.

The class of cases that I have seen suggests that this disease is largely a disease of the lymph and circulatory systems. We know that the nasal lymphatics are in close connection with the sub-dural space, and in many of the cases where the nasal symptoms are severe, we have severe meningitis and those conditions which render the patient despondent, as a direct sequence by continuity of structure. The profound impression on the nutrition shows also that the lymph system is very much affected.

In the history of previous epidemics of this disease marked reference has been made to different varieties, such as the pulmonary, gastro-intestinal, and other forms of influenza,

and I have asked a number of my friends in general practice, whether they had observed in recent epidemics as many miscarriages as had been described in previous epidemics. I found that, with the exception of the epidemic of 1889-90, there had not been so many noted.

Another reason for regarding this as largely a disease of the lymphatic system is the occurrence of the affection of the throat described by Dr. Seiler: that peculiar puffy condition which looks apparently like œdema of the larynx and œdema of the palate. When you incise these parts, however, you do not get a serous fluid. Sometimes you have blood and sometimes a mucoid material, or lymph which may exude in long, continuous strands.

Now as regards the use of quinine in influenza, I have often been asked what can be done to prevent the occurrence of the disease in unaffected members of a family in which it has appeared. I have always advised the use of quinine in ten to fifteen grain dose early in the morning. I am satisfied that large doses often act as a preventive, and that in these cases the quinine does not so readily produce the ordinary symptoms of cinchonism.

In using strychnine I think that the best preparation is the arseniate, which I give in the granules dosimetriques of Burggraeve, containing one-half a milligramme, or about one hundred and twenty-fifth of a grain. The patient takes three to six or more granules a day, and continues it for a month or two. In that way many of the sequelæ can be prevented.

DR. FRANK WOODBURY: I look upon influenza as essentially an intoxication. In Europe epidemic influenza, or the grip, is now pretty well accepted as having for its cause the bacillus of Pfeiffer. It is stated that pure cultures of this bacillus will reproduce the disease in animals, thus fulfilling the requirements of a specific, infectious germ. Pfeiffer's bacillus, however, is like the tubercle bacillus often found in association with the staphylococcus and the streptococcus and other bacteria of suppuration, thus accounting for the organic inflammations. As the influenza bacillus is not found in the blood, it probably acts by its products principally upon the nervous system.

It is very possible that the germ of influenza may have suffered some modification in its development and pathogenic effects, owing to different climatic conditions in this country from those of Europe, so that we should not be surprised to find modifications in the course of the American disease, such as Dr. Seiler insists upon. That there is any etiological difference between the two kinds of epidemic influenza has not been suspected; possibly Dr. Seiler's observations may have been upon an entirely distinct disease.

The portal entrance of the poison into the system is worth considering. In most cases the culture ground of the bacillus is probably located in the upper air-passages, and I am inclined to think that the tonsils and naso-pharynx are the special points of election. In others the bronchial mucous membrane is most affected, while in other cases the gastro-intestinal canal is the particular place of development. It has occured to me that, just as in the administration of morphine hypodermatically, the effects of the drug are most marked if injected in the neighborhood of the seat of the pain, although we know that the drug acts through the general circulation, in a similar way the well recognized varieties of influenza may be connected with the several culture-fields of the bacillus, the toxine acting most virulently in its immediate neighborhood, producing cerebral, gastro-intestinal, or broncho-pulmonary phenomena, which have been alluded to.

This leads me to speak of the prophylaxis of influenza. I can indorse what Dr. Cohen has said with reference to quinine. I employ it as much for antiseptic and prophylactic purposes as for its tonic effects. The mouth and throat should be kept clean by the use of mild antiseptics, and the naso-pharynx by the use of Seiler pastilles or Dobell's solution, and the throat carefully watched. There is no question in my mind that the disease is contagious; when it appears in one member of the family others are liable to be affected. This has been established by the local epidemic which was reported by Drs. J. Wm. White and Simes to this Society several years ago. It will be remembered as the case of Dr. S. S. White, who died of influenza in Paris, and whose body was brought to his home in this city, whereupon a number of persons who were in the room when the casket was opened contracted the disease although there were no other cases in the city at the time.

In the few cases where I have used benzoate of soda, I have been pleased with the result. I have especially relied on strychnine, given in the acid solution of the hypophosphites according to the formula of Dr. Gerhard. The strychnine is given in doses of 1-32 of a grain, gradually increased. With this I have used cocoa, and in regulating the diet I have found the juice of fresh fruits, such as the orange and pineapple, to be of service in assisting the weakened digestion. These juices have been shown to have considerable peptonizing power over albuminoids, and the salts they contain possess diuretic and antiscorbutic effects which are useful in improving the condition of the blood.

DR. WILLIAM S. STEWART: There is a great variety in the manifestations of influenza, but the ordinary influenza which is so common in this country, is certainly very contagious. The influenza of la grippe is a different affection from the ordinary influenza. I do not think that it is particularly contagious. I have seen grave and serious cases where no other member of the family was affected.

In regard to treatment, I wish to say a word as to the bromides, particularly in those cerebral cases that would be affected by quinine. I have combined the bromides with gelsemium with great benefit. In some of these cases, if you give quinine you only intensify the pain and delirium. When the cerebral suffering is relieved then it is important to give iron, quinine, and strychnine, and it may be aromatic spirit of ammonia, to tone up the system and to overcome the heart-depressing effect of the disease.

DR. COHEN: I am pleased to note that Dr. Curtin and Dr. Watson in some of their conclusions confirm those which I published in an article upon "Catarrhal Fever," contributed to the MEDICAL AND SURGICAL REPORTER, October 29, 1887, some time previous, therefore, to the enlarged experience which we now have. One point which I endeavored to make was that influenza is always with us, but that except in times of widespread epidemics it was only recognized as such by those who, through teaching or early experience, had had their attention specially directed to it. This is, I think, an important matter and will bear emphasizing.

I am also glad to note that experience has confirmed the usefulness of the salicylates in this disease. In the cases which came under my observation in 1885, 1886, and 1887, and upon which the paper referred to was based, I had found cinchonidine salicylate apparently curative, and so reported. I have more recently used sodium benzoate in early cases with much benefit, especially those in which there was a tendency to suppression or great diminution of urine or which exhibited severe pains in the loins.

The value of strychnine in the prevention and treatment of the distressing sequelæ cannot be overestimated. The drug should be given in small doses frequently repeated.

Drs. Curtin and Watson emphasize the great sweating; I have been much impressed with this in my own experience. I remember one case in an old man, in 1889, in which profuse sweating and subnormal temperature were the only objective symptoms of the disease. This continued for two weeks, and I am satisfied that if that patient had not been put to bed and kept there with the external application of heat and with the administration of hot drinks, of cocaine, and restoratives, he would have died, almost without realizing that he was sick. He had complained merely of discomfort in the throat, nothing to account for the symptom being discernible on examination.

DR. SAMUEL WOLFE: I have observed a considerable number of cases of the intestinal form in which the symptoms resembled those of dysentery, but the affection yielded to the same treatment as did other forms of grip. The affection of the nervous system is a very large element in the disease, both in its onset and its sequelæ. The variability of the seat of attack shows this to be the case. The sequelæ—insanity, meningitis, and neuritis—point to a secondary poison affecting the nervous system. Many chronic nervous affections date back to an attack of grippe.

Influenza is comparable to diphtheria inasmuch as we have the acute symptoms due to primary poisoning and the secondary symptoms due to poisons generated during the disease.

I would take exception to the statement that influenza is similar to the ordinary colds which we always have with us. The best treatment for an ordinary cold is trying to shake it off; this in influenza would lead to prolonged convalescence or sequelæ. The most valuable element in the treatment of influenza is rest. The patient can do better without any drug than without rest. This rest should be prolonged until the patient can make efforts without tire. This difference alone proves that influenza is dissimilar to an ordinary cold.

As to therapeutics, I believe that quinine is one of the best remedies, not in one large dose, but in smaller doses frequently repeated (4 grains every two hours) until some cinchonism is produced, and this should be brought about in the early part of the day. I would rather do without any other drug than give up quinine. In the intestinal form, salol is a valuable remedy, and may be combined with quinine. The neuritis is to be treated like other forms of neuritis. Hypodermatic injections of cocaine (in doses of from one-eight to one-half grain) near the seat of pain, and repeated twice in the twenty-four hours, relieves the pain not only for a short time but permanently, and brings about an earlier convalescence.

DR. COHEN: Replying to Dr. Wolfe, I did not mean to say, and I trust I did not say, that influenza is the same as in ordinary cold, but I wish to emphasize the fact that influenza is not merely an epidemic disease, that it is seen every year and every month, and that many cases of influenza are ordinarily mistaken for "colds," for acute catarrhs of nose, throat, bronchi, stomach, or intestines, and even in some instances for typhoid fever and for rheumatism. Influenza is at

times the easiest and at other times the most difficult disease to recognize. The opinion of those who have most closely studied the affection is that it is a disease of intoxication, due to a specific poison, depressing the organic nervous system. This poison may be the result of the development of a microbe, but as yet this microbe has not been definitely proved to exist. In consequence of the organic nervous depression we have, for example, labored respiration from pneumogastric failure even when the lung cannot be shown to be much involved. The general depression and the severity of symptoms not to be accounted for by signs discoverable upon physical examination, differentiate the disease from ordinary "colds." Besides this disproportion of symptoms to signs, there are a number of minor points—for example, general soreness or aching, or localized pain, such as infra-orbital or supra-orbital neuralgia, and the neurotic character of many symptoms such as dyspnœa and cough, and cutaneous hyperæsthesia. The general course of the affection is likewise significant. It is rarely confined to a single physiologic apparatus, but beginning as a coryza or a tonsillitis may end as a diarrhœa, or beginning with gastric symptoms terminate as a broncho-pneumonia or a laryngitis.

When the true nature of cases is not recognized and they are allowed to go untreated, or rest is not part of the treatment, serious sequelæ are often developed. It was the observation of such sequelæ, and especially of chronic broncho-pneumonia in children attending the Medical Dispensary of the Jefferson Medical College Hospital during my early years of service there, that first impressed me with the facts recorded.

DR. SEILER: The diversity of opinion as to symptoms and treatment lies in the fact that we indiscriminately speak of grip, influenza, and la grippe. We also speak of fever and catarrhal pneumonia. High temperature does not constitute fever. The disease consists of infiltration of the mucous membranes as a result of an intoxication. In American grip, the benzoate of soda is the best remedy. In influenza, quinine is of service. The treatment of the sequelæ is to be guided by their character.

DR. CURTIN: As to the effect of quinine, as stated by Dr. Seiler, I recall three cases of insanity following influenzal attacks, which occurred before any treatment was instituted.

DR. WATSON: It may be that Dr. Seiler has in mind catarrhal fever. In that affection there may be low temperature, moist tongue, and all of the symptoms which he has described.

As to antidotes, I have used benzoate of sodium in many cases, but did not get any better results than from other remedies, as salicin and the salicylates. I have seen five cases of insanity following influenza where quinine was not used, and many cases persistently using it which did not become insane. This should be distinctly stated lest Dr. Seiler's experience should be understood to be the usual one.

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**Pental an Excellent Anæsthetic.**

P. F. Feodoroff has experimented with pental in general surgical anæsthesia. This very stable substance does not become decomposed either in light or air; its specific gravity is about that of ether, and, like this latter, it is very volatile. Care must be taken to keep this substance removed from the fire; it burns with a very bright flame, but it has no explosive properties. The vapor of pental does not irritate the mucous membrane. According to Feodoroff, the duration of pentalization is from one to two minutes, and, the condition of anæsthesia once induced, it may be prolonged from two to five minutes. In about 50 per cent. of the cases the radial pulse is not modified, but otherwise the pulsations become more frequent, and sometimes there is arhythmia. It is principally during the first minute that disturbances of the circulation shows themselves; it is therefore, very necessary to be circumspect during the primary inhalations, and not to have recourse to the concentrated vapor of pental, except after the first minute, when the action of the heart will already be regularized. It is important to call attention to two peculiar effects of the drug: 1. Analgesia occurs while consciousness is still retained; the patient executes all the orders of the physician, feels the contact of the instrument, but does not feel pain. It would, however, be imprudent to operate before the complete loss of consciousness; the majority of accidents which have happened during the use of pental were due to reflexes occurring in subjects insufficiently anæsthetized. 2. From ten to fifteen minutes after a first adminstration of the drug it may again be used without its action being weakened; it would even appear that the subjects are still more susceptible to its effect. One must also be careful never to operate with a patient in a sitting posture, but always in the recumbent position, for fear of dangerous accidents. To resume: Pental is an excellent anæsthetic in operations of short duration.—(From *Univ. Med. Journal*).

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A METHODICAL man died in Berlin recently, at the age of seventy-three. When eighteen years old old he began keeping a record, which he continued for fifty-two years, which is the best commentary we have seen on the life of a mere worlding. His life was not consecrated to a high ideal. The book shows that in fifty-two years this "natural man" had smoked 628,715 cigars, of which he had received 43,682 as presents, while for the remaing 586,021 he had paid about $10,433. In fifty-two years, according to his bookkeeping, he had drunk 28,786 glasses of beer and 36,085 glasses of spirits, for all of which he had spent $5,340. The diary closes with these words: "I have tried all things, I have seen many, I have accomplished nothing."

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY

for March. Dr. J. F. W. Ross contributes a paper on

**Influences Affecting the Results in Abdominal Operations.**

He considers the subject under four heads: 1. The influences inherent in the patient. 2. The influences closely connected with the character of the operation. 3. The influences due to the atmosphere and surroundings of the place in which the operation is performed; and 4. The influences brought to bear upon the patient by the details of the after-treatment. In regard to the first of these heads, he thinks that while pus in wounds that have been made under aseptic or antiseptic precautions may at times be due to the conditions of the air or some carelessness on the part of the operator, it also may be due to some condition inherent in the patient. Conditions of the patient affecting the result of abdominal operations or of any operation, are scroffula, anæmia, malarial poisoning from bad drainage and impure drinking water, and perhaps a condition produced from eating improper or insufficient food. In such cases the system is unable to provide the proper barrier against infection, and, as a consequence, the wound does not heal kindly, and the patient does not do well from the very first. The presence of the tendency to bleed may seriously affect the results of the operation, as may also any organic disease in other viscera. The author dreads operations on patients suffering from renal disease more than in cases of heart disease. If the renal disease is sufficient to produce an œdema of the tissues the wound does not heal as kindly as it otherwise would do. The mental condition of the patient may also affect the result and the author reports a case in point in which the operation for the removal of a simple ovarian cyst was followed by an acute mania, due to fright. She died on the eighteenth day after operation. In this case it is interesting to note that the patient's brother was burned some years previously and that when the burn had healed he became maniacal and died insane.

In regard to the influences due to the atmosphere and surroundings of the place in which the operation is done, the author is of the opinion that we have been taught to pin too much faith to antiseptics and that we should learn to look further and pay greater attention to other matters than we do. He would not, however, discard antiseptics. He has found that "when the peritoneum has been opened in a contaminated atmosphere and closed again, the antiseptics prevent wound-contamination and assist the wound to heal kindly, but the poison introduced into the peritoneum at the time of operation is sufficient to produce irritation with a little more distention than one cares to see, with a little higher temperature and pulse than one cares to see, and, though the patient recovers, the progress of recovery is not as free from incident as it ought to be." He is satisfied, also, from his own observations that the entrance of a septic case into a building in which abdominal operations are being done on the same floor or the floor above, has an influence for evil on the results. When a patient dies from peritonitis after the removal of a simple ovarian tumor, where there can be no infection from within owing to the nature of the disease, he considers it of the greatest importance to criticise carefully the surroundings of the patient at the time of operation. He raises the interesting question of how far the fact of the operator having past through an attack of contagious influenza just previous to the operation affects the result. He also thinks that cases operated on in isolated houses among the mindle class, when the house has been put in thorough order before the operation, and when a trained nurse has been employed, have done better than any others. Each house thus becomes a little private hospital with one bed.

As to the influences brought to bear on the patient by the details of the after-treatment, the author is of the opinion that "a drainage-tube should be used after separation of many adhesions, and after washing out the abdomen for the removal of peritoneal fluid or septic material. When used for the detection of hemorrhage it should be removed in a few hours; when used after washing out the peritoneal fluid or septic material it should be used for a few days, and when removed a rubber drainage-tube should be passed through its centre, and left *in situ* for a few days longer, so that any subsequent collection of pus may readily find a track through which to burrow to the surface. When hysterectomy is performed by the extra-peritoneal method, and there have been many a adhesions to contend with, a drainage-tube should be used for a few hours above the stump. When hysterectomy is performed by the abdomino-vaginal method a drainage-tube should be passed into the *cul-de-sac* of Douglas from the front, even though the vagina be packed with iodoform gauze. The tissue around the cervix has a tendency to ooze, and enough blood may lodge in the *cul-de-sac* of Douglas to set up a fatal peritonitis."

The author condemns the use of so-called capillary drainage, produced by packing the glass-tube with iodoform gauze, and considers the practice a dangerous innovation. Where the drainage tube is used to detect hemorrhage, its usefulness is lost when packed with gauze. To check the hemorrhage it is necessary that the pelvis be kept dry. While blood-clot may be left in the pelvis with safety in some cases this does not apply to pus cases, where the blood is readily infected.

He has also come to the conclusion that peritoneal fluid is very apt to become infected,

and when peritoneal fluid is present in any quantity at the time of operation, as in cases of papilloma of the ovaries or tubercular peritonitis, it is better to wash out and drain the cavity than to draw off the fluid and close the cavity; the water thus takes the place of the peritoneal fluid, and, owing to its chemical composition, is not as apt to become inflected. The large quantity of albumen found in the peritoneal fluid in these cases must make it an admirable culture medium.

He does not place much reliance on the efficacy of purgatives for the relief of peritonitis following abdominal operations and thsnks that they are not of the value that many authors would have us believe. It is better not to operate at all than to do an incomplete operation for the relief of pus-tubes or suppurating ovaries.

Dr. Charles P. Noble discusses

**Profuse Menstruation.**

The following are the conclusions arrived at by the author:

1. Menorrhagia in young virgins is usually functional, due to disturbances in the vasomotor nervous system, or to relaxation of the tissues; in general caused by the rapid growth which at times takes place about the time of puberty. Because of its pathology, menorrhagia in young virgins is usually curable by general treatment.

2. Menorrhagia occuring in young childbearing women is usually due to some mishap in connection with pregnancy or parturition, such as the retention of products of conception, lacertion of the cervix or perineum retro-displacement of the uterus, subinvolution, inflammation of the uterine appendages, and pelvic congestion. Menorrhagia in this class of women is curable. It usually requires local treatment of an operative nature. When due to subinvolution and malpositions of the womb, operation is unnecessary.

3. Menorrhagia in women approaching the forties and in those who are older is usually due to gross diseases of the uterus, such as fibroid tumors, polypi, adenoma, or malignant tumors. Menorrhagia occurring in this class of women, except when due to advanced malignant disease, is curable, but almost invariably requires operative treatment applicable to the disease present in the particular case.

4. As menorrhagia is a symptom and not a disease, an exact diagnosis is requisite in every case. With the exception of young virgins it is desirable that a physical examination of the pelvic organs be promptly made. The importance of this examination is the greater with the increasing age of the patient. Special considerations should influence the practitioner to postpone the local examination in the unmarried unless it be reasonably certain from the symptoms that gross local disease is present.

5. There is no treatment for menorrhagia *per se*. By general measures, such as rest in bed and the use of digitalis, strychnine, and ergotine, pelvic congestion can be lessened, and in that way menorrhagia can be, at least in part, controlled; but it cannot be too strongly insisted upon that in every case of menorrhagia an exact diagnosis must be made and the oppropriate treatment addressed to the disease which is present.

The same author also describes "A New Uterine Curetting Forceps" and "The Perfect Needle Holder." Cuts of these instruments are given.

Dr. J. Adrian Goggans discusses the

**The Treatment of Chronic Diseases of the Uterine Appendages.**

Endometritis he regards as the most serious of the diseases peculiar to women from its consequences. He treats these cases by rest, vaginal irrigations, sitz baths, and in some cases ergot and hydrastis. Locally, he applies every fourth or fifth day some mild cauterizing agent, and generally prefers a solution of iodized phenol in glycerine, to the entire uterine mucous membrane either with or without previous dilatation, and follows this up with tampons of cotton (saturated with boroglycerine) in sufficient quantity to elevate the uterus. The principal signs which indicate that an operation should be performed are:

1. Those attending pelvic peritonitis, accompanied by tortuous and distended tubes, which may usually be felt in Douglas' pouch behind the uterus. This condition may be preceded by the history and symptoms of an abortion, a gonorrhœa, or a tubal pregnancy.

2. The physical signs of large and tender ovaries due to chronic abscess.

3. The physical signs of prolapsed and tender ovaries, accompanied by irregular hemorrhages, and incapaciting pains.

4. Some few cases where dysmenorrhœa is the principal symptom, with a probability of its being kept up by chronic disease of the ovaries and tubes.

5. Where hemorrhage is the principal symptom, accompanied by the ordinary signs of grave pelvic disease.

6. In a few cases of general peritonitis preceded by the symptoms of rupture of a pre-existing abscess, ovarian abscess, pyosalpinx, or abscess in the appendages developed during the progress of puerperal septicæmia.

Dr. R. S. Sutton, in a paper on "The Treatment of the Pedicle in Hysterectomy," says he is in doubt if any method can be uniformly depended on, yet every case should be considered on its own merits. The elastic ligature or the wire serre-nœud is a good method if the patient is not too fat, and amateur operators will do well to begin with it.

John G. Kerr, M. D., of Canton, China, contributes a translation of "The Tat Shang Pin, or Midwifery made Easy" a popular work on midwifery among the Chinese, in common use among the people, and the standard authority in all difficulty cases.

In the department of pædiatry is the report of the proceedings of the Section on Pædiatrics of the New York Academy of Medicine. Dr. William P. Northaup presented a paper on "Scorbutus in Infancy" a review of which has been published in the issue of THE MEDICAL AND SURGICAL REPORTER for March 31st, 1894, page 476.

THE VIRGINIA MEDICAL MONTHLY

for March contains a paper by Dr. I. S. Stone on

**The Importance of Early Diagnosis of Cancer of the Uterus.**

The author thinks that the uterus should not be removed save when the disease is confined to the cervix. If the disease has extended to the body of the uterus, it may be taken for granted that it has extended elsewhere, and cannot be entirely removed, in which case, thorough curretting and actual or chemical cauterization afford not only relief from pain, hemorrhage, etc., but probably prolong life as much as the more dangerous extirpation. The author urges that some effort should be made to arouse the general practitioner to an appreciation of the importance of watching patients more closely in order that the cases should be dealt with before they become hopeless.

**Membranous Croup.**

is discussed by Dr. John Dunn. The author believes that croupous laryngitis and laryngeal diphtheria are two separate and distinct diseases. The great difficulty of curing this disease lies not so much in the nature of the disease itself as in the region it has chosen to manifest itself. When the case is seen early, before the membrane threatens the closure of the larynx, the author advocates the administration of three or four grains of calomel with a quarter of a grain of ipecac and five grains of bicarbonate of soda, to be followed after four hours by a dose of castor oil. Pilocarpin may be given, provided the patient is robust and the case seen early enough. The usual expectorants and emetics should be avoided after the formation of the membrane, and the author sees little use for them at any stage of the disease. The writer advocates a warm, moist atmosphere for the room, believing it favorable to the casting off of the membrane. He also advises the impregnation of the air of the room with tar, which may be done by putting a table-spoonful of the ordinary commercial tar in half a pint of water and letting the steam from this pass into the room.

Tracheotomy should not be deferred till the patient is in the arms of death. The author favors the low operation, when it is possible, for the reason that the lower opening of the tracheal canula is then below the line of the membranous deposit.

Dr. W. E. Fitch, contributes a paper on

**Summer Complaint.**

The treatment, according to the author, should be conducted on the following lines: First. The child's strength must be sustained, and in all efforts to cure the diseace, its general welfare must at all times be closely watched; nor must its frality be overlooked. Second. Removal of intestinal contents. Third. Regulation of diet. Fourth. Administration of intestinal antiseptics. Fifth. Combating special symptoms. Under no circumstances should the natural diarrhœal discharges be trusted for the removal of the intestinal contents. The author advocates the use of calomel in one grain doses, every four hours, followed by a dose of castor oil. For children under one year, he makes the dose of calomel one-half grain. After the bowels are freely moved, the number of stools will generally grow less; but the persistance of dangerous nervous symptoms should invariably lead to a suspicion of retention of poisonous feces. The author finds it difficult to get the mothers to withold food from the child for a sufficient time to enable the poisonous material to be thrown off, therefore, he has given up the practice. When the stools are putrid, with an intensified fecal odor, it indicates the decomposition of proteid material. No other kinds of food can give rise to putrid odor except the albumins. In such case it is clear that the albumins should be withheld. While proteid food is withheld, one or more of the carbohydrates may be given. Of these arrow-root is theoretically the best; but the author has found that fresh soda crackers answer the purpose better. Rice may be allowed but children seldom like it. He has often allowed a baked potato without ever regretting it. Sterilized milk he regards as useful in the prophylaxis of summer compaint but not its cure.

Acid-smelling stools are due to the fermentation of the sugars and starches, but if you withhold all carbohydrates and put the child on cow's or breast milk, you will set up a putrid form of the diarrhœa, and transform a comparatively harmless form of the disorder into a harmful one. In mild cases you can still allow carbohydrates in small quantities: but if the case is severe and the child weak, withhold all carbohydrates for twenty-four hours, or until the tenesmus and tormania subside. On returning to food, milk alone should be allowed, as the carbohydrate which it contains (milk-sugar) is the least liable of any to continue the disturbances.

Whatever food is given in summer complaint should be carefully regulated qualitatively, and should be given in small quantities at regular intervals of considerable duration. Just enough food to maintain the child's strength is all that should be allowed. If the child is wet-nursed it should only have the breast at regular intervals—about every four hours.

The author has never had any success with lavage of the bowel. The author has frequently used the following prescription with success:

℞ Bismuthi subnitrat..... ʒiij
Pepsin saccharat..... ʒiss
Salol..... ʒj

M.—Make charts No. 12. —Sig. One before or after each feeding or nursing to child of ten to fourteen months old.

Opium is a drug much used and abused in this disease. In the acid form of the disease, while systemic poisoning is not present and where there is much pain and tenesmus, opium is indicated. Here the deodorized tincture is preferable, administered in chalk mixture with subnitrate of bismuth, which also has an astringent action. Still, however,

the pain may be assuaged by heat, and the bowel movements controlled alone by bismuth, while the use of opium is *entirely* dispensed with.

Dr. I. S. Stone reports a "Series of Twenty-five Abdominal Sections" with three deaths —one from shock, one from general peritonitis, and the other from sepsis and the pressure of a large tumor. The author states that he has never yet found an ovarian cyst in a negress.

Dr. N. L. Guice reports a case of

**Masturbation in a Female Child Eleven Months Old.**

The fingers of the right hand were firmly placed upon the vulva and the left leg brought across the right in position to increase the pressure, and was thus held in a condition of rigidity. Thus the child lay upon the back with the entire voluntary muscular system in a condition of tonic rigidity, the eyes closed and face and lips distorted. The fact that pleasure was experienced by the little victim was clearly evident; and when caused to desist, she would cry vigorously. Let alone, she would at once resume the practice, taking always precisely the same position.

Upon examination, the vulva was found to be normal, excepting the clitoris and minor labia, which were somewhat enlarged. Titillation of the clitoris would promptly bring about the muscular rigidity and other evidences of enjoyment, as exhibited when the child herself was masturbating.

The practice had probably been inaugurated by a colored nurse in order to secure quietude of the child. To break up the practice, the right hand was secured in a sling about the neck, and the thighs separated by means of a stick attached to either limb above the knee, to prevent approximation of the thighs. Added to this, the child was kept as much as possible in the arms of the mother when awake.

Dr. Hunter McGuire reports a case of "Tuberculosis of the Bladder" and advocates supra-pubic drainage of the bladder and rest, in the treatment.

Other papers in this issue are:

"Diseases of the Skin," by James C. McGuire, A. M., M. D.

"The Care and Treatment of the Insane in Private Practice," by J. T. Wilson, M. D.

"Some Nervous Effects of Digestive Disorder," by A. K. Bond, M. D.

"Ovarian Cyst — Laparotomy—Prolonged Delirium, etc.---Recovery," by R. S. Martin, M. D.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Puerperal Sepsis; Its Prophylaxis and Treatment.

Dr. Robert A. Murray, read a paper with this title. Antisepsis during labor, he said, was believed to be as necessary as in surgery. Three antiseptics could be managed easily—corrosive sublimate, carbolic acid and creolin. The prophylaxis should begin with a bath and a change of clothing. The vulva especially should be cleansed carefully. A new rubber cloth should be spread over a clean sheet, and over the rubber there should be a draw-sheet. The importance of an enema should not be forgotten. A vaginal injection of a 1-to-3,000 solution of corrosive sublimate or of a two-per-cent solution of creolin should be given before labor, but usually not after it. Creolin was to be preferred to corrosive sublimate, because it was something of a lubricant, while corrosive sublimate was distinctly astringent, and so facilitated laceration. An antiseptic pad and napkin should be applied, and never removed except for examination, which should not be more frequent than was actually necessary. The physician's hand should be scrubbed thoroughly and immersed in a 1-to-2,000 solution of corrosive sublimate or a two-per-cent. solution of creolin. The antiseptic pad should be applied again after the birth of the child and before the expulsion of the placenta. Retained membranes and pieces of placenta should be removed at once by the aseptic hand, and then an intra-uterine douche should be given. Fluid extract of ergot, in half-drachm or drachm doses, was to be recommended in the majority of cases. After urination an antiseptic solution should be applied. When there was a bad odor to the discharge a vaginal douche was to be ordered, but if the remaining finger showed that the foul discharge came from the uterus, it must be thoroughly curetted and a single intra-uterine douche given. In prolonged cases instruments were to be employed. The nurse should never be allowed to examine a patient. In case of sepis, the same general plan of antisepsis should be followed, but the vagina ought to be inspected so that the diphtheritic membrane might not be carried into the uterus.—*N. Y. Med. Jour.*

### The Use of Chloroform in Gynecology and Obstetrics.

Brennecke (*Munchener Med. Wochenschrift*) reaches a different conclusion from many observers with regard to the action of chloroform on the kidneys. He calls attention to the fact that where the patient has no bad symptoms after anæsthesia, albumin is invar-

ably absent from the urine, and *vice versa*. Serious renal troubles may develop after the administration of chloroform in patients who showed no previous evidences of the same. Albumin in casts (nearly always hyaline) usually disappears from the urine within a few days, coincident with the disappearance of unfavorable general symptoms, such as nausea, loss of appetite, etc.

The writer concludes that chloroform should be administered only when it seems to be absolutely necessary, and that it is contra-indicated in cases of renal disease. With the exception of fatty degeneration, he thinks that its use is attended with less danger in organic cardiac than in renal affections. He furthermore advises that its use in midwifery be limited, and that it be excluded in the treatment of eclampsia(?)—*American Journal of Medical Science.*

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### Dry, Scaly Conditions of the Epidermis.

Dr. Gordon Sharp (Leeds), for the prevention and treatment of chapped hands, and as an antiseptic and deodorizer for the hands advises:

℞ Spirit of camphor,
Spirit of nitrous ether,
Strong acetic acid, of each, 1 part.
Mix and add glycerin, 13 parts.

Wash the parts with warm water; dry, and rub in the liniment at bed-time. The application dries in a few minutes. It may be applied again in the morning, and washed off in a few minutes. Owing to the production of acetic ether, the application has an agreeable odor.—*British Medical Journal.*

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### Diphtheria.

As a local remedy, MM. Knopf and Levy, of Strassburg, employ:

℞ Papayotin .....3iiss.
Liquefied carbolic acid.....3i¼
Water.....q. s. ad 3iij—M.

The throat is painted with the above mixture every ten minutes during the first two hours. Subsequently it is used once every second hour.—*La Med. Mod.*

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### Ten Tests for Death.

An English physician writes to the London *Lancet* that he was called to see an old lady who was believed to be dead, but whose countenance looked natural and life-like, the eyes being open. The family, being extremely anxious, urged that all the tests of death be applied, and this was done in the following order:

1. Heart sounds and motion entirely absent, together with all pulse movement.
2. Respiratory sounds and movements absent.
3. Temperature of the body taken from the mouth the same as that of the surrounding air in the room, 62° F.
4. A bright needle plunged into the body of the biceps muscle (Cloquet's needle test) and left there, showed on withdrawal no sign of oxidation.
5. Intermittent shocks of electricity at different tensions, passed into various muscles and groups of muscles, gave no indication whatever of irritability.
6. The fillet test applied to the veins of the arm (Richardson's test) caused no filling of the veins on the distal side of the fillet.
7. The opening of a vein to ascertain whether the blood had undergone coagulation, showed that the blood was still fluid.
8. The subcutaneous injection of ammonia (Monte Verde's test) caused the dirty-brown stain indicative of dissolution.
9. On making careful movements of the joints of the extremities of the lower jaw, and of the occipito-frontalis, rigor mortis was found in several parts.

Thus of these nine tests, eight distinctly declared that death was absolute—the exception, the fluidity of the blood, being a phenomenon quite compatible with blood preternaturally fluid and at a low temperature, even though death had occurred.

10. There now remained the diaphanous test, which was carried out by the aid of a powerful reflector lamp yielding an excellent and penetrating light. The writer says: "To our surprise the scarlet line of light between the fingers was as distinct as it was in our own hands subjected to the same experiment. The mass of evidence was of course distinctively to the effect that death was complete; but, to make assurance doubly sure, we had the temperature of the room raised and the body carefully watched until signs of decomposition had set in. I made a visit myself on the succeeding day to assure myself of this fact."—*American Lancet.*

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### Lumbricoid Worms in Young Children.

Miller (*Jahrbuch fur Kinderheilkunde*, Vol. xxxvi, part 3, 1893), reports a case of a child, three weeks old, who passed an ascaris under the following circumstances: The child was born July 10th. On July 17th the cord separated, on the 18th inflammation of the umbilicus began, which terminated in a grangrene of the navel, with perforation of the small intestine, which was bound to the belly wall at that point. The child constantly thereafter passed the stool through the artificial anus. On August 4th a living female round worm was passed from this opening; it measured six inches in length. This is the only case in which so young a child has been known to pass a lumbricus. The infection in this case, the author thinks, probably took place through impure water used in the milk, or in washing the nipple. He does not consider that the worm had any causative effect in the perforation of the intestine.

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HER MOTHER.—I am surprised at Charles squandering so much money on a phonograph.
The Wife.—I am not. He always did like to hear himself talk.—*Brooklyn Life.*

## ARMY AND NAVY.

U. S. ARMY FROM MARCH 18, 1894, TO MARCH 31, 1894.

Captain William R. Hall, assistant surgeon, is relieved from duty as attending surgeon and examiner of recruits at San Francisco, California, to take effect upon the completion of his examination for promotion, and will then report in person to the commanding officer, Whipple Barracks, Arizona, Ty., for duty at that post.

So much of par 8, S. O., No. 60, March 12, 1894, from A. G. O. as relates to First Lieutenant Harlan E. McVay, assistant surgeon, is amended to direct him, on being relieved from duty at San Carlos, Arizona, by First Lieutenant Straub, assistant surgeon, to report in person to the commanding officer, Fort Huachuca, instead of Whipple Barracks, Arizona Territory.

Major Henry M. Cronkhite, surgeon U. S. Army, is relieved from duty at Fort Clark, Texas, and ordered to report in person to the commanding officer, Fort Reno, Oklahoma Ty., for duty at that post, relieving Capt. Wm. C. Gorgas, assistant surgeon. Capt. Gorgas, on being thus relieved, will report to the commanding officer, Fort Barrancas, Florida, for duty at that post, relieving First Lieutenant Robert S. Woodson, assistant surgeon.

First Lieutenant Robert S. Woodson, assistant surgeon, on being relieved by Capt. Gorgas, will report in person to the commanding officer, Fort McIntosh, Texas, for duty at that post and for field duty in the Department of Texas, relieving First Lieutenant Benjamin L. Ten Eyck, assistant surgeon. Lieutenant Ten Eyck, on being thus relieved, will report to the commanding officer, Fort Clark, Texas, for temporary duty at that post.

By direction of the President, Lieutenant-Colonel Samuel M. Horton, Deputy Surgeon General, will report in person to the president of the army retiring board, at San Francisco, California, for examination by the board.

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THE physicians of the United States now number 118,453; New York leads with 11,171; Pennsylvania has 9,310, and Illinois ranks third with 8,002.

## NEWS AND MISCELLANY.

THE advance of surgery can furnish few more singular illustrations than is supplied by an operation in one of the London hospitals last week whereby the breast of a blackbird was fastened to a woman's face as a substitute for her nose, which had been so damaged that it had to be removed. The woman, who had been housemaid in a hotel, had been struck in the face by a descending lift, which caused the injury that led to the operation. The operation has proved perfectly successful, with every appearance of the woman being provided with a useful nasal appendage, though how it will perform its functions when the cure is complete remains to be seen.

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A BOARD of medical officers will meet Monday, April 16, 1994, in Washington, D.C., for the purpose of examining candinates for appointment to the grade of Assistant Surgeon in the Marine Hospital Service.—*Ex.*

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THE next meeting of the American Medical Association will be held at San Francisco, on the first Tuesday in June, 1894, instead of on the first Tuesday in May, in order to permit of a discussion of the Code by the various State Societies that meet just before the meeting of the National Association.—*Pub. Opinion.*

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THE Arkansas State Board of Health has been given power to revoke the license of any physician who is guilty of habitual drunkenness.

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THE Medical and Chirurgical Faculty of Maryland has placed in this dispensaries of Baltimore, cards ten by fourteen inches, reading as follows: "Watch a baby's eyes carefully for a week after birth. If they looked red or run matter, take it at once to a doctor. The child may become blind if not treated properly." The lesson taught by this card should be learned by every one in charge of an infant. No inflammation of an infant's eye is trivial. Home remedies are not to be trusted. Medical advice should be sought at once.—*Popular Health Journal*

THE

# MEDICAL AND SURGICAL REPORTER.

No. 1937. PHILADELPHIA, APRIL 14, 1894. VOL. LXX—No. 15

## ORIGINAL ARTICLES.

### THE SURGICAL USE OF COCAINE.

B. MERRILL RICKETTS, PH.B., M. D., CINCINNATI, O.

I look upon cocaine as the greatest acquisition to the list of anæsthetics since the day of their discovery.

That it is in a measure dangerous cannot be denied, but as all powerful and useful drugs are more or less dangerous, we must console ourselves with the thought that a certain class of surgery and its good results could not be accomplished without them.

Admitting then that it is dangerous, even in the hands of those most skilled in its use, we are all the better prepared to rely implicitly upon its effects in producing anæsthesia for operations where it is desired not to produce unconsciousness.

What can be more dangerous than unconsciousness from any cause other than natural sleep?

Yet there are certain individuals whom it is better to make unconscious than to subject them to the fright which often attends operations, especially if the operation is to be grave or prolonged.

I have found that a few persons are not very susceptible to the effects of cocaine, while others are very much so. While this is the case, I do not believe that the effects are as have been reported, instantaneous. No more so than the effects of strychnia, atropia or morphia.

Such cases I consider nothing more than fright or ordinary faint. It is a physiological impossibility for a person to fall unconscious instantly upon the application of cocaine to the system in any way, especially if that person be in a normal physical and mental condition at the end of fifteen minutes from the time of its application.

There are more means of determining the safe application of cocaine than of chloroform or ether, and I believe that the bad results from the use of cocaine are to be more attributed to the operator than are the bad results of chloroform or ether. This I believe is due to the fact that physicians are not so familiar with the use of cocaine, and the exceeding uncertainty of chloroform and ether.

The amount that I have used in a given operation has varied from one-eighth to seven-and-one-half grains. The latter amount was used in a plastic operation for the restoration of both the left lower eyelid and right upper lip. This was in a case referred to me by Dr. D. D. Bramble and the amount was consumed within one and one-half hours.

The pulse reached 120 and respirations 24 per minute, but nothing more unpleasant arose.

On the other hand I have had the most alarming symptoms following the injection of but three-quarters of a grain (Merk's crystals) into the lower lip for the removal by cautery of an epithelioma.

This was in the case of a man age, 69, of a highly nervous temperament. The excitement was intense; the pulse 140 and respiration 30 per minute; he was generally discomboberated without unconsciousness or delirium.

He yelled at the top of his voice; pounded the couch, myself and assistant, Dr. Spargur. Talked rationally and expressed his chagrin that a man as old as he was should make a fool of himself, he also added that his condition was about the same as when he was drunk at the age of twenty.

Quietude was soon established and he was entirely over the stimulating effects at the end of one hour and a half.

In this case the symptoms were more aggravated than any of the six cases of poison that I have encountered among the one thousand in which I have used cocaine.

The other cases manifested similar symptoms, but very much less severe, but one, however, having delirium and none unconsciousness.

I have found that primary union is, with cocaine as with all local anæsthetics, less likely to take place. This may be accounted for, perhaps, by the hemorrhage poured out from the capillaries that have become dilated as the secondary effect of the cocaine. The first effect is to contract the capillaries which afterwards become over dilated, and thus allows hemorrhage to take place, which prevents union.

This has also been charged to the use of chloroform and ether.

I have used cocaine without a slough in the following operations, thus showing the very broad range of surgery in which it has been personally applied:

1. Circumcision.
2. Cutaneous tumors.
3. Subcutaneous tumors.
4. Varicocele (open operation.)
5. Hydrocele (removal of sac.)
6. Tubercular Glands.
7. Phymosis.
8. Periphymosis.
9. Internal Urethrotomy.
10. Removal of Ingrowing Nails.
11. Fistulæ (Sundry)
12. Hemorrhoidal Operations.
13. Amputation Finger and Toes.
14. Tenotomies.
15. Plastic Operations.
16. Incising Abscesses.
17. Neurectomies.
18. Neurotomies.
19. Preparing Surfaces for Grafts.
20. Removing Grafts.
21. Anæsthesia for Cautery and Caustic.
22. Amputation of Scrotum.
23. Removal of Testicle.
24. Ligation of Varicose Veins.
25. Exploratory Incision for Bone Disease.
26. Removal of Bones of the Feet and Hands.
27. Removal of Bone Spiculæ.
28. Removal of Foreign Bodies.

In conclusion I would offer the following *maxims.*

1. Solutions should not be made except at time of operation.
2. Cold water solutions will add materially to the good effects of the cocaine.
3. An operator should accustom himself to but one kind of cocaine and confine himself to the use of that kind as he does chloroform.
4. The operator should prepare the solution himself and not entrust it to an assistant.
5. Only small amounts should be used especially in the young, the old and in highly nervous persons.
6. Small quantities should be used in operations upon the face, head and neck.
7. Operations should be made as soon as possible after the area has become anæsthetised that as much as possible of the solution may escape through the wound and thus not enter the general circulation.
8. The finest needle should be used, and it's length should be sufficient to traverse the line of incision intra-cutaneously with but one puncture.
9. Intra-cutaneous and not subcutaneous injections should be made, because there is less of the drug absorbed and because there is no pain to result from cutting tissue beneath the integument.
10. The nearer the injection is to the end of the member the less is the amount of absorption.
11. The prepuce, fingers, toes, hands and feet can be constricted in such a way as to present to a considerable degree the entrance of the solution into the general circulation.

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MRS. UPPERCRUST—"You go abroad a great deal lately, do you not Mrs. Newmonie?"

Mrs. Newmonie—"La! yes, my dear. Why, we're in Paris so much lately that I call us reg'lar Parisites!"—*Vogue.*

# THE EXTRACTION OF FRAGMENTS OF IRON FROM THE VITREOUS BODY WITH THE MAGNET.

F. C. HOTZ, M. D., CHICAGO, ILLINOIS.

The vitreous body of the human eye is an exceedingly sensitive tissue; it is very quickly affected by any disturbance of nutrition and it is very slow in the repairing of its deranged texture. After any injury therefore, it is apt to waste away, to shrink and seriously impair the functions of the eye. On account of this great sensitiveness of the vitreous the removal of foreign bodies with forceps or scoops, which instruments necessarily caused considerable derangement of its texture, was usually followed by so disastrous results that it was seldom attempted, and that the presence of a foreign body in the vitreous was generally regarded as equivalent to the loss of the eye.

It was, therefore, a most happy idea of Dr. McKeown, of Belfast, in 1874, to employ for the extraction of an iron chip, a magnetic probe which through a scleral incision was slowly passed into the vitreous down to the foreign body, and the iron attracted by the magnetism was found attached to the probe when this was withdrawn from the eye. As the probe passed in and out over the same route it caused but very slight derangement of the vitreous and the eye recovered so well that the patient was able again to read small print.

Dr. McKeown's instrument was a simple bar magnet, 8 inches long and 1-8 inch thick tapering off to a point at both ends. And though since then the ingenuity of men has furnished us with instruments much superior to his, both in power and shape, his merits remain undisputed of having opened a new field for ophthalmic surgery.

There are now two kinds of instruments in use, the *permanent magnet* and the *electro-magnet*.

As an excellent representative of the first kind I show you here the permanent magnet constructed by Dr. Gruening, of New York, in 1880, and will describe its construction by the inventor's own words.* "I joined several magnets into a bundle, thus making a powerful magnetic magazine. * * * The two extremities of a number of magnetized steel rods placed parallel to, and at a little distance from each other, are fitted into iron caps one of which is provided with a delicate point of malleable iron, 32 mm. long, 1 mm. wide and 0.3 mm. thick. This point is powerfully magnetic, sustaining with ease, a weight of 15 grammes. Chips of iron weighing from 1 to 50 centigrammes, when placed into the vitreous of recently enucleated animals eyes, are attracted toward the point at a distance of 1 to 5 mm., and withdrawn with the greatest facility." When not in use the point is screwed off and the magnet placed in an iron frame to preserve its magnetic power.

When we consider that the weight of the particles of iron found in the vitreous body seldom exceed one centigramme, we must admit that Gruening's magnet is certainly powerful enough for the purpose. It has also the advantage of great convenience; for it is light, easy to manipulate, portable, and ready for use at any time and in any place. The only faulty point which has been urged against this instrument, is that it gradually loses power. But while admitting this fact, I can easily convince you by a *demonstratio ad oculos* this loss of power is so infinitely small that it can scarcely be appreciated even after many years. This magnet was bought in 1881, and as you see still lifts this key weighing nearly half an ounce. And then should the instrument become actually too weak, the steel rods can be remagnetized by an electric company at a very small expense.

In the electro-magnet—as the name indicates—the magnetism is developed by an electric current circling round a piece of malleable iron. Its use, therefore, requires a battery and connecting wires, and its efficacy is entirely dependent on the perfect working of the electric apparatus. All this makes the electro-magnet a more complicated and cumbersome instrument than Gruening's magnet; nor is it as convenient as the latter, because whenever you wish to use it you have to have a battery with you. The only thing in its favor is its greater power; but I dare say a fragment of iron which a good Gruening mag-

*New York Medical Record May 1, 1880.

net cannot extract from the vitreous, will not be brought out by the more powerful electro-magnet.

I am free to make this assertion upon the ground that the electro-magnet has proved a failure in the hands of our surgeons under precisely the same conditions under which I was unable to extract the small particle of iron with a Gruening magnet in the following case :

*Fragment of iron, weighing 2 milligrammes, in the vitreous one week; vitreous cloudy, but iron visible; magnet failed; eye enucleated.*

The bit of iron had entered the eye by the sclero-corneal border and without wounding the lens had made its way into the vitreous. At the time of the examination, one week after the accident, the eye was considerably inflamed but still could count fingers; the pupil readily dilated under atropine and the lens was quite clear; the vitreous was hazy, the obscuration being decidedly more pronounced on the temporal than on the nasal side; and in the denser temporal cloud a bright shining body could be seen with the ophthalmoscope. An incision was made through the tunics of the eyeball below the external rectus muscle, and the point of Gruening's magnet was introduced in the direction where I had located the iron scale. But repeated efforts with the magnet were unsucessful and finally I had to enucleate the eye. Immediately after enucleation I removed the cornea, iris and lens, being careful not to disturb the vitreous, and I could trace the track the magnet had left in the vitreous, from the scleral incision straight on to the foreign body, a minute scale of iron. It was, therefore, evident the point of the magnet had undoubtedly been in contact with the iron fragment, but why then did it not bring it out? This question was answered by the following experiment : I again introduced the magnet through the scleral incision and slowly passed it along the visible track in the vitreous toward the foreign body, and when it was yet one millimetre from the iron this jumped and clung to the point of the magnet; and when the latter was slowly withdrawn the iron followed it for a distance of 2 or 3 millimetres; but then it suddenly sprung back to its former place as if forcibly jerked back by an elastic string. This experiment was repeated several times and always with the same result. The whole vitreous was opalescent, but around the metallic scale it was streaked with white fibrinous strings which held the foreign body so firmly within their grasp that when I tried to remove it with the point of a scalpel, the whole vitreous was lifted up, and it required considerable traction to break these resisting bands. It is obvious that against such resistance any magnet would have been powerless.

Under much more favorable conditions and with very good results was the magnet employed in the following two cases:

Case I. *Chip of steel, weighing 9 milligrammes, in the vitreous 24 hours; magnet successful; good vision restored.*

The steel entered through the sclera 6 millimetres from the nasal margin of the cornea and could be plainly seen with the ophthalmoscope in the center of the vitreous. The small wound in the sclera was enlarged, the point of Gruening's magnet introduced in the proper direction, and on the second attempt the chip of steel was brought out. The conjunctiva was closed over the scleral wound by a fine silk suture, and both eyes were bandaged for 5 days. The recovery was very rapid and one month later the sight was almost normal.

Case II. *A scale of iron, weighing 3 milligrammes, in the vitreous ten days; magnet successful, eye recovering with traumatic cataract.*

This case is remarkable for the unusual tolerance shown by the eye to the pressure of the foreign body in the vitreous, inasmuch as after ten days there were no signs of inflammation. The small scale of iron had entered through the cornea and made its way through the temporal portion of iris and lens into the vitreous where it could be seen as a bright shining body though the lens was already partly opaque. It was successfully extracted with the electro-magnet through a scleral incision, and the eye made a quick recovery, but the lens, of course, became entirely opaque.

It is evident the operation promises the best results if it is undertaken at a very early period, before the iron has been enveloped in a dense exudate, and before the lens or the vitreous or both have become so cloudy as to render an ophthalmoscopic examination impossible.

You have seen that the movableness of the iron fragment is an indispensable condition for the success of the magnet operation; and another condition almost as essential is this, that the foreign body can be seen, or at least located, with reasonable accuracy. For if we do not know its location in the vitreous we are truly and literally fishing in the dark and trusting to good luck to find it. But "luck" is an element we should not reckon with in surgical operations. In 33 cases where the fragments could not be seen in the vitreous and the surgeons "went it blind and for luck," the iron was extracted in 14 only, while the operation was successful in 13 out of 15 cases in which the foreign body could be seen; and the two pieces which could not be extracted, were found to be embedded in the retina.

But before we decide upon the magnet operation we have not only to consider the question whether the chances are favorable for the extraction, but we should also consider the far more important question whether we have good and sufficient reason to believe that the removal of the foreign body will save the eye. I, for my part, at least, have always taken this position, that the operation is not performed for the purpose of proving the possibility of removing particles of iron or steel from the vitreous, but that its ultimate aim is the preservation of the eye either as an organ of vision, or, at least, for its cosmetic value; for every one would rather keep his own eye though it be blind, than to wear an artificial eye. Always acting on this principle that the operation was to benefit the patient, I could never persuade myself to undertake it on an eye in which the lesion was so serious, or the inflammation induced by the foreign body so violent and extensive, that I was convinced disfiguration and atrophy of the eyeball would be the inevitable result even should I succeed in extracting the particle of iron. What satisfaction can it be to the patient to know the iron was successfully extracted with the magnet if his eye does not recover, or has to be enucleated soon afterwards for fear it would cause sympathetic inflammation of the other eye? Is it not more rational, is it not far better for the patient as well as the surgeon under these circumstances to abstain from the magnet extraction and to remove the eyeball at once.

We have already learned the magnet operation is not always successful; we have seen it fail to extract the iron or steel in 21 out of 48 cases which I found reported in the journals. But if now we examine the reports of the 27 successful extractions in order to find out how many patients receive a lasting benefit and what the condition of those eyes was, which were actually saved by the operation, we receive the following information. In 6 cases the operation was done very soon after the accident before inflammation had set in, and all 6 eyes recovered. Of 13 eyes which showed a moderate degree of inflammation and more or less haziness of the vitreous, 10 were saved; but of 8 eyes with violent inflammation and cloudiness of the vitreous none could be saved, they all had to be enucleated because the irido-choroiditis continued although the foreign body had been removed. These results sustain my opinion of the impropriety of operating on an eye in the advanced stage of inflammation. But I am well aware these views are not shared by all surgeons. For among those 48 cases in which the magnet had been tried, I found a goodly number of eyes which manifestly were in a hopeless condition before the operation; eyes with their tunics extensively lacerated; eyes with the vitreous chamber filled with blood; and eyes showing the signs of atrophy, that inevitable consequence of severe traumatic irido-choroiditis. To operate on such eyes is, in my opinion inexcusable, for neither science nor the patient can gain by it. But for some surgeons the presence of a piece of steel or iron in the vitreous seems to be a sufficient indication for the use of the magnet, no matter what condition the eye is in—because in their anxiety to increase the list of their operations they sometimes forget that the welfare of the patient should always take the first rank in all our deliberations and actions.

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ASSYRIAN RECORDS.—Layard, in his "History of Nineveh," mentions that the national records of the Assyrian Empire were written on bricks in characters so minute as to be scarcely legible without the aid of a microscope, and that, in fact, a variety of this instrument was found among the excavations.—*Boston Commonwealth.*

# COMMUNICATIONS.

## THE IMPORTANCE OF EARLY RECOGNITION AND TREATMENT OF OBSTRUCTIVE DISEASES OF THE UPPER RESPIRATORY TRACT.*

JOSEPH S. GIBB, M. D.,† PHILADELPHIA.

The introduction of a subject so time-worn and stale might require an apology were it not that notwithstanding there is a plethora of literature there still remains a singular indifference and lack of appreciation of the merits of the matter in the minds of the general practitioner. Doubtless much of this is due to the very voluminous character of the literature, which tends rather to interest those for whom the subject has an especial attraction. We read much of the histological structure of the various hypertrophies, and numerous are the instruments introduced for their destruction. We read less of the best means of demonstrating their existence, the etiological factors concerned in their production, and the prophylactic measures which may be adopted to prevent their development.

Perhaps no single abnormal condition is productive of more marked alterations in physical beauty and healthy functions than diseases producing obstruction in the upper respiratory tract. The anxious and watchful mother views with sorrow the freckling or tanning of her child's face. How much more disagreeable than these are alterations in the facial lines to such a degree as to cause a face to be expressionless; and when to this is added partial deafness, with all its unpleasant effects, we have a picture which any careful mother should strive to avoid. Were as much care bestowed on the important functions of the nasal chambers as is generally given to the skin or other tissues more directly under the eye, we would have fewer of these unpleasant pictures. Nor is this marring of physical beauty the sole deleterious result of these conditions, it can be proven that serious and perhaps grave interference with important functions follow in its wake.

In order to have a proper appreciation of the importance of the subject we will review for a moment, and in a cursory manner, the anatomical structure and physiological purposes of the nasal chambers and their contiguous structures.

The bony nasal chambers consist of three scroll-like bodies, the turbinate bones, two of which, the middle and inferior, are accessible in the living subject, which form the sides of the chamber. A septum, separating the nasal chambers, which is reinforced by a plate of cartilage in the recent state. These turbinated bones divide the nasal chambers into three meatuses—superior, middle, and inferior—into which open the various sinuses or foramina which communicate with the accessory cavities—namely, the frontal sinus, the ethmoid and sphenoid cells, the antrum of Highmore, and also the lacrymal duct. All these structures in the living subject are covered with mucous membrane well endowed with bloodvessels and nerves, whilst over the turbinate bones the tissue is erectile or cavernous.

The situation of these chambers, the peculiar construction of the bones, the unusually large surface of mucous membrane for so small a cavity, and the very generous blood supply, bespeak important functions. Bosworth claims three: (1) the first and very important function in respiration; (2) an aid in phonation by acting as a resonant chamber; (3) as an olfactory organ.

The atmospheric air as it passes through the nasal chambers is brought in contact with a comparatively large surface of mucous membrane which is rendered warm by the free blood-supply and moist from the secretion of the numerous mucous glands therein contained. The effect of this contact is first to abstract from the air

*Read before Philadelphia County Medical Society, March 14, 1894.

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dust and other foreign bodies, and secondly to add to the inspired air warmth and moisture. This latter function is most important. It has been computed that over 7000 grains of water are expired from the lungs in twenty-four hours; and Aschenbrandt has demonstrated by a series of carefully conducted experiments that the source of this moisture is in the nasal chambers.

From this brief and very imperfect glance at the anatomical position and functional purposes of the nasal chambers we may draw a few important lessons. Interference with the proper and easy inspiration of air through the nasal chambers is productive of diseased conditions, not alone of those organs themselves but of the more important respiratory structures within the chest.

It cannot be doubted that inspiration of air into the air vesicles imperfectly warmed, deprived of the moisture which Nature intended it should have, must exercise a deleterious influence on the delicate mucous membrane lining these cells. I am not ready with statistics to prove the relationship between pulmonary and bronchial affection and obstructive diseases of the upper air tract, nor do I deem it necessary, for it is a matter of common experience and observation that those children whose nasal chambers are obstructed either directly by hypertrophies, polyps, etc., or indirectly by hypertrophied pharyngeal or faucial tonsils, are sunken-chested, prone to attacks of acute bronchitis and coryza, and in many respects are less healthy than other children. I am well aware that these conditions are often the result of a constitutional vice which in itself renders the subject less robust, still I am more than ever convinced that removal of the local effects of this diathetic condition results more effectually in a return to a normal condition than any plan of treatment directed solely to the condition itself. Nor is it alone the respiratory tract that suffers from these abnormal states. I have before remarked that children so afflicted are apt to be in a condition of poor health generally, and it has occurred to me that perhaps this may be not entirely due to the diathetic condition which is so frequent a concomitant, but rather that the lungs, being supplied constantly with a vitiated air, *i. e.*, air insufficiently warmed and moistened, failed to supply the blood with a healthy, proper pabulum and hence the tissues suffer. Be the explanation what it may, we must not lose sight of the fact that a condition of ill health frequently does exist and we should bend our energies to ascertain the cause and seek its remedy.

It is not the object of this paper to elaborate on the various methods of treatment, but rather to inquire into the causation and to endeavor to point out means which may be taken to ameliorate the conditions existing and to prevent the development of more serious ones. Especially is it desired to inquire into the causative influences of obstructive diseases of the upper air-passages in young children.

Eliminating all those effects of imperfect or perverse fœtal development such as occlusion of anterior or posterior nares, cleft palate, etc., we have conspicuously prominent in the catagory of obstructive lesions in the upper respiratory tract hypertrophic conditions of the turbinate bodies, of the pharyngeal, faucial, and to a lesser degree the lingual tonsil.

A glance at the records of any of our large throat and nose clinics will convince one that these abnormal conditions are far from rare; nor does even this showing give us a thoroughly accurate conception of their frequency. Too common is it to ignore or carelessly treat the various catarrhal symptoms presented to us, and this indifference on the part of the profession has led to a corresponding indifference on the part of the laity, so that only those cases of pronounced obstruction are brought to the notice of the general practitioner. Were the nasal speculum used as freely as the stethoscope or clinical thermometer we would be astonished at the result. Again, certain hypertrophic conditions have but comparatively recently received any measure of attention from the profession. Though faucial hypertrophies have been observed and studied from remote times, it was not until a very recent date that Meyer gave to the profession a clear idea of the significance of hypertrophic conditions of that collection of adenoid tissue at the vault of the pharynx known as the pharyngeal tonsil; nor is the importance of the subject to-day appreciated by the rank and file of the profession, notwithstanding that much has been written about it and many instruments devised for its removal. Situated

as it is in a somewhat inaccessible or rather unobservable portion of the upper pharynx, it is only by the use of the rhinoscope that its presence can be clearly demonstrated; this being the case it is patent that it must be frequently overlooked.

With these facts before us it is clear that, whereas our clinics show us that these states are common, they give us no adequate conception of their prevalence.

At the clinic of the Episcopal Hospital it is the custom to carefully examine the nasal cavity, the pharynx, and post-nasal surfaces in every case that applies for treatment, irrespective of the fact that the subjective symptoms point to lesions in this or that locality; and in children of tender age, where a rhinoscopic examination is not feasible, if there is any suggestion of disease in this locality a finger is introduced back of the soft palate and over the vault of the pharnyx to demonstrate by tactile sense the presence or absence of any abnormality. It is surprising as a result of this procedure to note the number of cases in which there are lesions of the upper pharnyx of which the symptoms have been overlooked by the parents.

In considering the etiology of these hypertrophies it is as well to treat of them collectively, for whereas they are often separate and distinct lesions and exist independently, they are often associated and their etiology, so far as our knowledge goes, is in many respects similar.

In the case of the glandular tissue there can be no doubt that in a few instances these hypertrophies are congenital, doubtless the effects of an inherited vice—syphilis or scrofula—carrying out the well-known tendency of these dyscrasiæ to affect lymphatic and glandular tissue. Though this view is combated by no less authority than Meyer, who leans to the view that it is always an inflammatory process in a tissue which normally is largely developed in infancy and childhood, at the same time it is difficult to explain the presence of this state in very young infants unless we presume this inflammatory process to have taken place during its prenatal existence. Those cases developing subsequent to birth donbtless have as a starting-point an inflammatory or catarrhal origin.

We have demonstrated the frequency of hypertrophies of the glandular tissues and turbinates in children, and have admitted a few cases may be congenital, which leaves the vast majority to have its development subsequent to birth; and as it is our belief that its causation lies in some condition outside of the child, at least, in part, it is now our endeavor to seek out those causes and, if possible, lay down certain laws looking to their eradication or, at least, amelioration. Here as with many other diseases of insidious approach, an early recognition is productive of much good.

Among the general causative agencies which it is not entirely within our power to relieve, may be mentioned atmospheric conditions incident to residence in temperate climes, and especially near the seaboard; the method of heating houses in cities by dry air frequently derived from an unsanitary source; carelessness in the dressing of infants and trusting them too much to the care of servants who unnecessarily expose them. All these and others exercise an influence in the production of the disease, but only in a general way. The prophylactic remedies are obvious and suggest themselves.

The various catarrhal conditions which the above enumerated disturbing influences of our environment occasion, are of much importance from an etiological standpoint. There can be no doubt that it is here we have the starting-point of the hypertrophic process. A simple coryza is neglected; the child is not even protected from the causes which produced it—the result, one coryza succeeding another the entire season. The effect of a long-continued inflammatory process is precisely the same in the nasal and pharyngeal tissues as in the other tissues of the body—namely, increase in the connective-tissue growth, increase in the cellular growth. And it is just here by a knowledge of the effects that the family physician's advice and counsel can be of so much value and save so much misery and suffering to the child—so much mental anxiety and mortification to the parents. I believe that parents should be taught that a coryza is by no means so simple or harmless an affair as is commonly believed. It is better to err on the right side—better by far to give some attention (possibly needless) to a few attacks of coryza than to sit quietly by doing nothing and permitting the production of obstructive masses in the upper air-passages that

may alter the child's expression and possibly injure the health.

Parents should further be taught that repeated coryzas indicate a diseased condition of the nasal or pharyngeal mucous membrane demanding prompt and thorough treatment. The physician should himself insist on a careful examination aided by the speculum and rhinoscopic mirror, and should lay down a plan of treatment which his ingenuity will suggest, and persevere with it until the conditions yield; and I believe in this way, and in this way alone can we hope to have any measure of success.

Conspicuous in the category of special causative agencies may be mentioned the eruptive diseases of childhood, and especially those in which the fauces and nasal chambers are involved in the diseased process. Foremost among these may be mentioned diphtheria. The well-known tendency of diphtheritic processes to attack glandular tissue is well exemplified in the post-nasal spaces. We are familiar with the appearance of the diphtheritic membrane on the tonsils, but usually the examination of the other mucous surfaces is not made, and we remain in ignorance as to the extent of this process into the nasal chambers and vault of pharynx. Doubtless if careful examination was carried out in every case we would find the proportion in which these structures are involved to be very large. I have no doubt that many of the cases of so-called re-infection are in reality those in which there has been an involvement of the pharyngeal tonsil in the diphtheritic process. When an examination of the tonsils reveals an absence of the familiar membrane and a subsidence of the inflammatory condition, we are lulled into a sense of security and perhaps relax in our vigilance unmindful of the fact that the disease is perhaps making insidious inroads at a spot beyond our unaided view. However, we are not concerned with this at present; sufficient is it for us to know the extreme susceptibility of the mucous surfaces in this disease.

After the subsidence of the diphtheritic process it is very common to have a catarrhal condition continuing for a considerable period; this is especially noticeable in cases in which the nasal mucous membrane has been implicated; though it frequently occurs where there has been no perceptible involvement of the nasal chambers, and I believe it is just in these cases that there has been a diseased process going on at the vault of the pharynx. The explanation of this mucous discharge and other evidences of a catarrhal condition is doubtless due to alterations in the nutrition of the part, in consequence of the high grade of inflammatory action, and also to septic absorption. Were an examination made at this time we would likely find a hypertrophic condition either in the nasal turbinates or the pharyngeal and faucial tonsil. Though doubtless the majority of these cases do well without any special treatment directed to the part, yet in a certain number the catarrhal condition persists, and especially is this likely to occur in those children who seem prone to catarrhal states, and the foundation is laid for the formation of masses of hypertrophied tissue.

The beneficent offices of the family physician can be here admirably employed. It is not wise to pass over lightly the persistence of a catarrhal state after the subsidence of the inflammatory symptoms. Treatment employed at this time and persisted in until an amelioration takes place, can be productive only of good.

Scarlatina, as is well-known, expends at least a part of its energy on the mucous membrane of the fauces; though, unlike diphtheria, rarely involves the nasal chambers. Here the inflammatory action is so high, often to the production of false membrane, as to exercise a baneful influence upon the nutrition of the tissue and aid in the production of hypertrophies. We are all familiar with the fact that hypertrophies of the faucial tonsils are a frequent sequela of this disease. The same process that gives rise to hypertrophies in this tissue is at the same time exerting its influence on the tissues of the vault.

It is needless to dwell on this; the too familiar sight of catarrhal conditions as sequelæ of scarlatina precludes any argument to the contrary as to its position as a causative agent in the conditions under consideration. Nor is it hardly necessary to refer to the necessity for prompt treatment—one word, however on this point. It seems to me an imperative duty on the part of the medical attendant to insist on an examination, and if necessary subsequent treatment in every case where a ca-

tarrhal condition evidenced by a mucous or mucopurulent discharge from the nose, a thick voice, and mouth-breathing persists, after all evidences of the exanthemata have passed away.

Measles, though commonly regarded as a light and insignificant disease, is exceeding apt to leave some trace of its existence. The explanation of this is evident. Not commonly menacing life, it is, however, very active in its attack, and this activity is exerted on the mucous surfaces in the entire respiratory tract. Mothers should be informed of the fact that with care the course of the disease will be benign, but without it there is extreme probability of a catarrhal affection with all its unpleasant consequences being left as a sequelæ. And here, as with others, active treatment should be insisted upon if the catarrhal symptoms persist after the subsidence of other evidences of the exanthemata.

The other exanthemata and febrile diseases, such as rötheln, variola, varicella, typhoid fever, etc., exert a certain amount of influence as causative agents, but only in a general way, as any alteration in health will do. The diseases mentioned, viz., diphtheria, scarlatina, and measels, exert a special influence because the diseased condition seems to expend itself on the mucous surfaces, producing alterations and perversion of function.

The clinical picture presented by sufferers from obstructive diseases of the upper respiratory tract is absolutely characteristic, and especially is this true as regards the alteration of facial lines and changes in expression. Naturally this obstruction to the entrance of air by the normal route, viz., through the nose, necessitates its seeking some other mode of ingress to reach the lungs; the only other way is through the mouth, and hence we have the condition of mouth-breathing with all the discomfort and unpleasant effects which such a condition entails. Long-continued mouth-breathing brings into play muscles about this orifice not usually called upon for excessive work, and at the same time nominally puts at rest muscles about the nose whose functions are not called into play; the result is an alteration of facial expression to such a degree in well-marked cases as to give to the child a stupid, almost idiotic appearance. The obstruction in the case of the pharyngeal tonsil may become so excessive as to encroach on the pharyngeal orifice of the Eustachian tube, interfering with the proper supply of air to the tympanic cavity, thus inducing catarrhal or inflammatory conditions of the mucous lining of this tube and also of the tympanic chamber. The result of this is dullness of hearing or even complete deafness.

The normal course of the secretion from the numerous mucous glands in the nasal chambers is obstructed and hence flows back into the naso-pharynx; added to this we have a greatly increased secretion from the adenoid vegetations at the vault. During sleep this mucous collects in the pharynx, and as the child is obliged to breathe through the mouth, we have associated loud snoring with rattling and gurgling of air through the mucous secretion; hence the sleep of the child is restless and fitful and the annoyance to other members of the household excessive.

We have then as the salient features of a case we are attempting to portray: mouth-breathing, snoring, rattling of mucous in the fauces, and disturbed sleep; a dull, listless expression of countenance; hardness of hearing, and in many cases impairment of general health, causing the child to be anæmic, sunken-chested, prone to catarrhal attacks, and of stunted growth.

Much has been written and various are the opinions as to the treatment of these distressing conditions. We are not concerned in this article whether it is the proper method to remove adenoid growths by forceps, curette, or finger; to diminish hypertrophied turbinates by means of galvano-cautery snare or escharotics, but a few words in conclusion as to the management of cases in their incipiency may not be amiss

Mothers should be urged not to neglect a persistent snuffle in her child, to regard as trivial the continuance of a mucous discharge after diphtheria or the exanthemata. Physicians, on the other hand, should not pass these complaints lightly by ignoring them or directing in an indifferent manner some simple and likely inefficient remedy.

The management of hypertrophies at this early stage is as simple as the results are happy. After a careful examination the nares and upper pharynx should be cleansed of mucous by an antiseptic and detergent spray, *e. g.*, Dobell's solution,

Seiler's tablet, Listerine in diluted solution, etc., and then applications made to the affected mucous membrane of an astringent or alterant, depending on the condition of the parts. Should we find simply an increased secretion with no appreciable alteration in the turbinates, tonsils, and surrounding tissues, it is likely we will accomplish all that could be desired by directing spraying of the nares thoroughly by one or other of the solutions mentioned faithfully until the membrane presents a normal appearance and the secretion ceases.

In cases still farther advanced in which we find the turbinates quite red and somewhat swollen; the pharyngeal tonsil secreting more mucus than normal, and rather large; the faucial tonsil red and somewhat hypertrophied, we will find it advantageous to use some application to diminish the inflammatory condition. These applications maybe made quite painless by spraying the parts with a 5 per cent. solution of cocaine or introducing a cotton tampon saturated in the same solution. In the nares a solution which has gained favor in the various clinics devoted to these diseases is that of iodine. The strength of the solution may be graded by the severity or obstinacy of the case. It is well to begin with a weak solution, increasing the strength as the necessities of the case demand. In some cases which resist this plan of treatment a touch of the fused bead of chromic acid along the turbinates will often accomplish the desired object; this latter plan should be immediately followed by the antiseptic spray to dilute and limit the destructive power of the escharotic. It is merely necessary in these early cases to touch the mucous membrane lightly to produce a superficial eschar; the resulting slough and subsequent contraction will so squeeze the blood-vessels as to bring about the desired diminution in the size of the tissues.

The pharyngeal tonsil also in many cases respond satisfactorily to application of iodine on a pledget of cotton carried by an applicator so curved as to pass readily behind the soft palate and up to the vault. Glycerole of tannin has been found to act very happily, though perhaps a little more unpleasant in its effects. The application of chromic acid (fused) to a pharyngeal tonsil should not be advised, though undoubtedly as useful as in the nose, unless the operator is steady and familiar with making applications by the aid of the rhinoscopic mirror.

It would be hardly necessary to refer to the treatment of catarrhal and slight hypertrophic conditions of the faucial tonsils the result of the causes named, were it not that here, in spite of the ready accessibility of the part, they are subject to neglect. The same process of cleansing is as necessary as in the other hypertrophies, after which an application of a solution of 60 gr. to the drachm of nitrate of silver, glycerole of tannin, or in stubborn cases producing a superficial slough by fused chromic acid, will probably answer every purpose.

In the more advanced cases or in those which fail to respond to the above-outlined plan of treatment and a steady increase of the hypertrophied tissues occurs, there is but one plan which should be carried out at as early a date as possible, namely, a destruction of the hypertrophied tissue. The various plans to accomplish this object will not be touched upon, but can be readily learned by consulting any of the modern treatises devoted to the treatment of diseases of the nose and throat.

In recapitulation the object of this paper has been to call attention to the following points:

1. The importance and desirability of early attention to diseases of the upper respiratory tract consisting of the nose and nasopharynx.

2. The production of alteration in nutrition and possibly pulmonary and bronchial troubles by hypertrophic conditions of the upper respiratory tract.

3. The etiology of these states referring to the influence of environment and especial mention of diphtheria and the exanthemata as prominent factors in this category.

4. The prevalence of these conditions.

5. Carelessness and indifference in both physician and patient as to the various catarrhal states which are believed to be the precursors of the diseases under consideration.

6. The necessity of early treatment and the power for good exercised by the family physician in these troublesome conditions.

7. The clinical picture presented by these unfortunates, laying especial stress on the alteration in facial expression and the distressing and annoying condition of the child during sleep.

# A CASE OF SPONTANEOUS ABSORPTION OF A CATARACTOUS LENS.*

T. B. SCHNEIDEMAN, M. D.†

A. B., aged 65 years, male; vision of the left eye began to grow dim twenty years ago. The dimness increased until he became entirely blind in that eye, two years after the trouble began. Has never had pain, injury, nor inflammation in the eye. At Wills Eye Hospital, which institution he visited at that time, one of the surgeons informed him that he had a cataract and advised operation for its removal, but the patient did not consent on account of the excellent vision which he enjoyed with the other eye.

The blind eye remained in the same condition, so far as the patient knows, until 5 years ago, when he observed a slight improvement. The sight continued to improve slowly, so that he was again able to distinguish large objects, the entire course being unattended with any pain.

*Present condition.* Eye of normal appearance externally; pupil round and reacts to light and convergence. Iris markedly tremulous with the movements of the eyeball. Fundus reflex of normal intensity throughout region of the pupil, except at the upper part where it is concealed by a dense gray membranous opacity. Closer examination shows that this membrane is freely movable, the lower extremity floating behind the iris, the upper portion being attached above. The membrane is evidently the remains of the capsule of the lens. There were a few small opacities in the vitreous, the rapidity of their movements proving that structure to have become fluid. The fundus was distinctly visible in all its details, and could be seen with a convex lens (+ 11). The nerve is decidedly pale and presents a shallow cup; the vessels are narrow and fewer than in health. The nerve is evidently atrophic. With + 11 the vision equals 12|200. The organ in its present condition presents exactly the appearance of an eye operated upon successfully by discission.

The best attainable vision with the correcting lens is low, but this is due to disease (atrophy) of the optic nerve and not to opacity of the media. Low as is the vision, if the case had been operated upon the result would still have been counted a success.

The interest in this case attaches chiefly to two points: 1. Complete absorption of the lens, together with its nucleus, occurring in a subject of the age of this patient; and 2. That this process should have gone on to completion without the supervention of glaucoma. Dislocation of an opaque lens is met with not infrequently, but the organ is found unaltered, at least as to the nucleus, years after the luxation has occurred, its presence in the anterior chamber causing repeated and destructive attacks of inflammation from the increase of tension to which it gives rise.

Absorption is, of course, the rule in the youthful eye when the fluid of the anterior chamber is permitted to gain access to the substance of the lens proper—a fact which is taken advantage of in the operation of discission. The infrequency of this occurrence in the adult eye is shown by the unsuccessful attempts of Beer to apply the same procedure to such eyes before the indications for the operation had been established; of twenty-nine eyes subjected to the operation, success was attained in only a single case.

The possibility of rupture of the zonula is greater where the lens has become opaque, because this structure participates in the degenerative changes which the whole lens system undergoes; and the more advanced these changes the greater likelihood of such an occurrence, as in hypermature cataract with considerable shrinking and atrophy of the organ. Such shrinking of itself exerts traction upon the suspensory ligament, and such traction may well be partial and affect one portion of the circumference more than the rest, and which yields at that point; in the case reported this point was situated at the inferior attachment.

The fluid condition of the vitreous noted was probably an important factor in bringing about the result; this condition may very likely have existed prior to the lesion of the suspensory liagment, the lens having lost some of the support pos-

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teriorly and normally furnished by the contents of the vitreous chamber in consequence of the alteration in that structure.

The text-books refer to dislocation of the lens as a late event in the history of cataract. Thus Fuchs observes: "The shrinking of the hypermature cataract affects not only its thickness, but also its equatorial diameter. In proportion as the latter diminishes in size, the zonula of Zinn is stretched, and thereupon undergoes a corresponding atrophy of its fibres. Consequently, the attachment of the lens becomes imperfect. Spontaneous luxation even of the lens may take place through partial or total rupture of the zonula. . . ." Again, after remarking "that spontaneous restoration of sight is extremely rare in senile cataract with a a hard nucleus," he admits the possibility of such occurrence in three ways: By the resorption in the exceptional cases not only of the cortex, but also of the nucleus to such an extent that nothing but slight opacities remain. The other possibilities to which he refers are the formation of a Morgagnian cataract and spontaneous dislocation of the lens, but without absorption.

Soelberg Wells speaks of dislocation due to gradual relaxation or elongation of suspensory ligament, or its partial rupture. In such a condition, he adds, a very slight shock to the eye, which may have been unnoticed by the patient, will produce dislocation of the lens.

Berry (*Diseases of the Eye*, p. 100) speaks as follows: "After the condition of maturity has existed for a longer or for a shorter time, further changes may take place, which are characterized as stages of hypermaturity. The opaque cortical substance may to some extent shrivel from loss of fluid, and in this way a little of the sight—as a rule, only a very little—be regained."

The gradual improvement in the vision raises the question whether the lens was actually dislocated or whether the rupture extended into the anterior capsule, giving access to the aqueous humor, causing gradual absorption of that organ as in the operative procedure of discission, or whether the improvement can be explained by the solution of the opaque lens after dislocation into the anterior chamber. The latter is the position usually occupied by the lens after luxation.

Perhaps the gradual improvement observed by the patient depended upon a partial displacement of the opacity. This cannot be determined with certainty; the patient did not come under observation until the process, whatever its exact nature may have been, had gone on to completion. In any event complete absorption of the lens in the adult is a rare termination of cataract.

## A REPORT OF EIGHT CRANIOTOMIES; WITH REMARKS ON THE TREATMENT OF LABOR IN CONTRACTED PELVES.*

DANIEL LONGAKER, M. D.

When labor is rendered pathological by the existence of contraction of the pelvis, certain deviations from the normal occur which it may be well for us to glance at here. These have reference to the fœtus and to the process of dilatation. Normally the head rests in the pelvis before a single pain occurs, even in a multiparous patient and in a primiparous weeks before the advent of labor partial descent and partial flexion will have taken place. In the latter the absence of this adaptation on the approach of labor is significant of disproportion between the presenting part of the child and the pelvis, and either the head is not in relation with the pelvic inlet or it is too large.

So long as engagement has not taken place even the experienced may be in doubt of the nature of the presenting part on mere digital examination. Too much emphasis cannot be placed upon this one point. A pelvis relatively empty and the presenting part reached with difficulty by the examining finger means, very frequently, the existence of narrowing. This is true even if found very early in labor and in a primipara before labor. All such cases demand the fullest investigation. If the attendant is not competent to make a careful estimate of the degree of pelvic narrowing, and finds this suspicious sign of its existence, he should request expert aid without delay. It will not do to leave such a case to chance. It is inexcusable to conclude, that since the pains are in-

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frequent and the os is undilated nothing can be done, and therefore the doctor may go home to finish his peaceful slumbers or to attend to his usual routine of calls.

The dilatation of the os is slow and the pains are irregular. A bag of amniotic fluid may be forced down, distending even the perineum, but when it has ruptured dilatation will be found incomplete. The os is undilated and remains *undilated*. As a rule, however, it does not long remain undilatable. All that is required to secure dilation is advancement of the presenting part.

The general management of this class of pathological labor may next be considered. Unless clear ideas upon the subject of treatment are generally diffussed, it will certainly be a long time before craniotomy becomes an obsolete operation. Time was, when it was more frequently done than the forceps operation. The time will come when even its present relative infrequency will no longer be known, and to aid in bringing this about is the chief object of the present contribution.

If the obstetrician has not informed himself fully of the relation of the child to the pelvis and of the conformation of the latter before the advent of labor, no time should be lost in doing so as soon as he sees the case. External examination, either alone or combined with internal, will disclose the exact relation of the fœtus to the parturient canal. The rectum and bladder must be empty. Much can be learned by external examination of the size of the fœtus and of the extent of the disproportion between the head and the pelvis. Ether should be given if necessary. Relaxation of the abdominal parietes is thus secured. The hand may also be passed into the vagina, although I have not often found this requisitie. The position, rate, and intensity of the fœtal heart-sounds should be noted early. Pelvimetry will afford valuable data, and it should never be omitted. I refer to instrumental and external measurements, having no experience with the recent instruments for taking the internal diameters. It must be admitted that there is a need for such, and I believe the instruments of Skutch, Hirst, and others will fill a real want.

I know of no method to differentiate between a generally contracted pelvis and a flat one other than this, and a knowledge of this fact is of the greatest practical importance. Thus a conjugate of three and a half inches, with ample transverse diameters, is a trifling affair alongside of the same conjugate with a proportionate shortening of the transverse diameters. In the latter the mechanism of labor is totally different, the treatment may differ and the prognosis is much graver. But, fortunately, the flat pelvis is the type we usually meet with. In this list it existed in all save one, or, at most, two cases. In estimating the conjugate I have limited myself to the digital method. One or two fingers are introduced into the vagina, at the same time depressing the perineum; the finger or fingers are directed upward until the round sacral promontory is reached. The other hand separates the labiæ, and with the index finger the point of the subpubic ligament is marked. The distance from this point to the tip of the finger resting upon the sacro-lumbar articulation is the diagonal conjugate. I believe a deduction of three quarters of an inch from this will give an approximate measurement of the true conjugate in most cases. I am convinced the true measurement will be underestimated more frequently than overestimated by this plan. In a true conjugate under three and a quarter inches no difficulty will be experienced in reaching the promontory with the index alone.

As to the difference in mechanism. In the generally contracted pelvis the head enters, if at all, in a state of extreme flexion. In the flat, between flexion and extension, both anterior and posterior fontanelle on about the same plane. The bi-parietal diameter adjusts itself to the so-called lateral conjugate—the line from the symphysis to the hollow of the sacral wing—and the bi-temporal diameter is in relation with the true antero-posterior diameter of the pelvis. Thus the jutting promontory of the sacrum may be passed by a head of moderate size, since the bi-temporal diameter is rarely much above three inches, and half an inch less than the bi-parietal. In addition, the head tends to enter the pelvis and pass the obstruction in a position of the lateral obliquity, the sagittal suture nearer to the promontory than to the symphysis. This peculiar mechanism is sometimes spoken of as the cause of dystocia. I have even known of attempts to force the lateral occiput to the front under this mistaken impression. It is needless to say this should not be done. The membranes

should be carefully protected; early rupture is to be avoided. If anterior obliquity of the uterus exists the patient should be placed on her back and a bandage should be firmly and evenly applied. Nothing answers better than a stout piece of muslin wide enough to extend from below the trochanters up to a level with or a little above the fundus uteri. This the obstetrician himself secures firmly by means of large safety-pins. When properly and early done, I am sure many a case of malpresentation and serious dystocia may be prevented.

The risk of infection should not be increased by repeated digital examination. After the peculiar features of the case have been learned, they are unnecessary, can do no good, and may do harm. A period of judicious expectancy is quite proper, and if the contraction is not too great and the fœtal head of average size or under, the maternal efforts may overcome the disproportion. I have seen this more than once where the conjugate has been under three and a half inches. During this time all possible means are employed to preserve the patient's strength. Easily assimilable food is to be taken, and a moderate dose of opium is often of advantage. During the expulsive stage, quinine sulphate in a single fifteen-grain dose, strong coffee, and, occasionaily, alcohilic stimulants are appropriate. Encouragement and sympathy are to be extended to the patient. From time to time the fœtal heart sounds are noted. As soon as it is evident that the woman's unaided efforts are insufficient and before the child's life is endangered, delivery must be assisted. I am convinced that the use of the forceps, and especially of the axis-traction forceps, is proper. Applied at the right time and in a proper way an average-size head may be delivered when the conjugate is three and a quarter inches. In a paper published in the *American Journal of Obstetrics*, May, 1877, I report several successful cases where the contraction was even greater. I would prefer the forceps to version because failure to deliver does not involve sacrifice of the child's life. If any doubt exists of the possibility of speedily extracting the after-coming head, version should not be done. To resort to version after the forceps have failed seems illogical since there must be greater uncertainity of being able to deliver the after-coming head quickly after a decided disproportion has been thus demonstrated. Beside this there is considerable danger of rupture of the uterus when the operation is undertaken after the waters have been drained away and when it is contracted on the fœtus. To make version and then allow the child to die in order that we may not be compelled to perforate a living child's head seems to me equally wrong. Nor do I believe that craniotomy is rendered easier when the head is last. My own views is that with forceps at the proper time, just as great a degree of disproportion, if not greater, may be overcome and with less risk to either mother or child than with version. I would not choose the latter operation unless I was sure the head could be quickly extracted.

None of the details of an aseptic major surgical operation should be omitted. As such, the application of the forceps at the superior strait is to be regarded. Undue force is not to be used. It will render the result, so far as the child is concerned, as bad as craniotomy, and for the mother worse.

I think it no exaggeration to say in advance that the management of the following case offers a marked contrast to the plan just sketched. And yet the case is but a counterpart of all the rest, with little variation in unimportant details. Its history is given without further comment.

Case VII.—In the latter part of April, 1893, I was asked to see Mrs. S., a native of Poland, who was then living at the rear end of a court not far from my residence. In this, her fourth labor, she had first the services of a midwife, who concluded after very active labor had existed over three hours, that a physician ought to be summoned. She told me she had only given ʒj of the fluid extract of ergot, and that in spite of very severe expulsive pains no advance whatever had been made in the position of the head. The doctor, a regular practitioner and a man of some obstetric experience, attempted to apply the forceps but failed, and at the end of an hour decided to call on a friend and neighbor, also a well-qualified practitioner—one who had served a term as interne in one of our largest hospitals. Together they succeeded in getting the instrument on the head, but ordinary traction efforts failed to advance it. Finally, bracing the feet against the edge of the bed, the forceps

slipped and the operator landed against the wall. At 12, midnight, it was concluded that forceps could not deliver the child. This was *eleven* hours after the membranes had ruptured, and during all this time the woman had been in very active labor, which had been in progress about twenty-four hours. However, podalic version was made, but now the real difficulty seemed to begin, and all the power two strong men could bring to bear on the delivered body failed to extract the head. Efforts at extraction were continued until the vertebral column parted and the body was torn from the head. At this juncture it was decided that the head could not be delivered unless it was first crushed, and this I was asked to do by the physician first summoned. Arriving at the house I found doctor number two had abandoned the case, the midwife alone in attendance. The remarkable advice had been given to summon an ambulance and send the woman to the Philadelphia Hospital, three miles away. The woman was then having short, rapidly succeeding pains, the uterus in tetanic contraction. Her appearance was extremely anxious, pulse frequent, and temperature above normal. The body of a very large male child lay on the bed between the thighs. The vulva was œdematous, the labiæ minora being swollen to the size of one's flattened hand. There was an offensive odor of decomposition. The head was in the uterus above the plane of the pelvic inlet and attached to the body by integument only.

After irrigating external genitalia and vagina, a catheter, introduced into the bladder with great difficulty, withdrew a few ounces of urine. The entire vagina was greatly swollen, and that there was no sloughing afterward was a matter of surprise to me. The left hand introduced into the uterus found the face looking to the right, an ear just above and behind the symphysis. The midwife held the child's body up out of the way, the physician in attendance steadied the head through the abdominal wall, and thus perforation by means of the Blot perforator was quickly made. This is a straight instrument. The brain was broken up thoroughly by passing the point of the instrument all around in the cranial cavity. Without flushing this, the Braun craniocast was quickly adjusted, the head collapsed, the opening being near the base of the cranium, and the entire operation was concluded in less than ten minutes. As the head escaped its resiliency caused air to be sucked into the perforation, and the sound emitted was something similar to that observed during the first inspiratory effort of a half drowned baby. Mistaking it for this, one of the assistants exclaimed, "And can it be possible!"

The placenta was quickly expressed, the uterus irrigated with a large amount of hot water, then with a 1:2000 bichloride of mercury solution followed by more hot water. Tha child was a male and weighed over nine pounds minus blood and brains. The diagonal conjugate, measured after delivery was exactly four inches. A liberal estimate would give three and a quarter inches for the true, the conjugata vera (8. 2 cm.). The brief details of this woman's parturient history which I learned after the delivery was completed may not be uninteresting.

Her first labor was long and difficult, and the babe, though small, was born dead. I could not find out whether instrumentally or not.

In her second pregnancy premature labor occurred at the end of the seventh month as the result of a fall, and twins were born, the first one living a few days, and the second seven months.

In the third labor the babe also perished; she was septically infected and sick in bed two months.

At 10 A. M., on the day following labor there was a normal temperature, and pulse 96. In about two weeks she was up and about, and I believe made a perfect recovery.

I have given the history of the cause in full because it is fairly representative save in a few unimportant particulars. For this reason a more detailed account of the other cases is omitted.

All were seen in consultation, the writer being called after labor had existed many hours, and, as a rule, when one plan of treatment after another had failed to effect delivery. Various oxytocics, including ergot, had been given; forceps of various designs had been applied, and failing, version had been attempted, with what success is seen in the case just detailed. It is needless to say the child's life had ceased in nearly every case. In spite even of a parturient history, that would of itself be suggestive of pelvic deformity, this was rarely suspected. Nor did the peculiar

mechanism and course of the labor at once impress themselves upon the minds of the attendants.

The contraction in none of the cases save the first was very great. The labors were insuperably obstructed by the large size of the children.

In Cases IV., V., and VIII. the greatest difficulty was met with in the extraction of the body, and this was accomplished finally by perforating the thorax, applying the cranioclast, and completing the delivery by traction on this. I am sure it would otherwise have been impossible.

And yet Case IV. has given birth to a living child since the craniotomy, without any special difficulty.

A word in ragard to Cases I. and V. The first should never have been delivered by craniotomy. An early Cæsarean section would have saved the child and given the mother a chance. When the conjugate approximates two and a half inches (0.063 m.) the difficulty to be anticipated in exacting an eight-pound child is not small. The fact that conjugate narrowing to this degree is, as a rule, associated with transverse shortening is not to be forgotten.

This was the only fatal case.

Case V., seen with Drs. De Young and Leopold, is in some respects the most unique of the entire group. Lying across the bed she was truly a mountain of flesh; her weight must have been between three and four hundred pounds. The mere making of a digital examination was exhausting. The skin covering the abdominal parietes was as hard as parchment. Subcutaneous tissues and muscles were waterlogged and infiltrated with fat. It was one of the rare instances in which abdominal palpatation would be impracticable. The amniotic fluid was in excess. There was early prolapse of the cord. The attendants had utterly exhausted themselves in their efforts to advance the head, and failing, had attempted version. Although the head was still very high and hard to reach from below, no special difficulty was experienced in perforation. The extraction was difficult, however, because of the enormous size of the child. I regret that it was not weighed. The woman made a rapid recovery. Attempts to learn

In conclusion, I want to emphasize the following points:

Insuperable obstruction of labor because of pelvic contraction is a frequent condition.

Arrest of the head at or above the pelvic brim is domparatively easy of recognition by attention to the details of external palpation, by the combined method and by the course of the labor.

Disproportion between the head and pelvis ought always to be recognlzed early in order that correct principles of treatment may be adopted.

Forceps may be employed when, after a period of judicious waiting, it is evident that the natural powers unaided are incapable of driving the head beyond the obstruction. Their use must be attended with all the care usually observed in the execution of a major surgical operation. If the disproportion is evidently very marked, leading to doubt of their successful use, an alternative should be decided on at the outset in the event of their failure. This will obviate the needless loss of valuable time.

Podalic version may be made where the membranes have not been long ruptured, and when the operator is reasonably sure of encountering no great difficulty in the extraction of the after coming head. It is of doubtful expediency after the forceps have been applied unsuccessfully.

An experience of two symphysiotomies goes far toward convincing me that this operation is destined to take high rank in the list of life-saving obstetric procedures; that it is *the alternative* when, in a contracted pelvis of moderate degree (not under 6.7 c. m.), the obstruction cannot be overcome by other means, and that it will go a long way in the direction of rendering the horrible operation of craniotomy obsolete and the Cæsaraen section under the relative indication unnecessary.

I finally want to express my belief that in assuming the management of a case of labor we, as physicians, at tha same time assume the solemn and sacred obligation of saving two lives; we dare not neglect or refuse to do anything which will conduce to this end. The social condition, whim, or desire of patients must not be allowed to swerve us from this conclusion—that the mother and her unborn child have equal claims upon us. Moreover, what is in the interest of the one is usually in the interest of the other. In our determination not to destroy the living, though unborn child, we are supported alike by the dogmatic teaching of the Church, by sound ethies, and by the latest science.

| No. | Date | Age | Pregnancy | Nationality | Pelvis | Presentation | Duration of labor | Delivery attempted by | Sex | Weight of child | Result | Remarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Jan. 21, 1882 | 39 | First | Germany | Conjugata vera estimated 2½–2¾ in. | Cephalic prolapse of cord | 36 hours; waters had drained 18 hours | Forceps | M | 8 lbs. | Death on 8th day | |
| 2 | Nov. 25, 1885 | 29 | Fourth | Ireland | Conjugata vera estimated 3¼ in. S. bat | Brow | 24 hours; membranes ruptured in 18 hours | Three pairs forceps; cephalic version | M | 10 lbs. (minus brain) | Gradual and slow recovery | See American Journal of Obstetrics, vol. xx, p. 469 |
| 3 | May 30, 1888 | 18 | First | United States | Conjugata vera estimated 3¼ in. Justo minor | Vertex, R. O. I. *a.* | 24 hours; membranes ruptured in 7 hours | Wallace, Simpson, and axis-traction forceps | F | 7 lbs. | Out of bed on 12th day | |
| 4 | Nov. 5, 1891 | 22 | Second | Austria | Conjugata vera estimated 3¼ in. Justo minor | Vertex, R. O. I. | 48 hours; membranes had ruptured early | Hodge and Simpson forceps | .. | 7 lbs. | Perfect recovery | Has born a small child sice; no difficulty |
| 5 | Feb. 19, 1892 | 38 | Seventh | Russia | Normal; woman anasarcous | Prolapse of cord | 36 hours; membranes ruptured over 24 hours | Forceps, then version | M | Huge | Perfect recovery | This woman was of enormous size, and there was no descent of the head whatever; hydramnion also present |
| 6 | March 27, 1892 | 22 | First | Russia | Conjugata vera estimated 3¼ in. S. flat | Vertex, L. O. I. | 18 hours; membranes ruptured in 6 hours | Forceps and perforation | M | Large | Perfect and rapid recovery | Has since born a living child; no difficulty |
| 7 | April 29, 1893 | 28 | Fourth | Poland | Conjugata vera estimated 3¼ in. S. flat | Face | 24 hours; membranes ruptured over 12 hours | Forceps, then version | M | 9 lbs. | Recovery | Head had been torn off when I first saw the case |
| 8 | June 26, 1893 | 28 | First | United States | Conjugata vera estimated 3¼ in. S. flat | Vertex, R. O. I. *a.* | 40 hours; membranes ruptured in 6 hours | Forceps repeatedly slipped off; A. T. failed | M | 9 lbs. | Recovery | |

# TRANSLATIONS.

## A PRIMARY SARCOMA OF THE STOMACH.

The rare occurrence of this disease has induced the author, H. Westphalen, to give an accurate account of the case, together with the results from an autopsy and the microscopical examination of the specimens.

The patient, male, aged 30, was sick one year. The symptoms were principally intense pains in the epigastrium, which were independent of digestion or ingestion of food. Occasionally vomiting occurred, principally before breakfast, and consisted of mucous and acid secretions. At times there were some eructations of gas unconnected with any taste or odor. The increased salivation was an early symptom, which disappeared with time. The patient was able to feel a swelling in the epigastrium, which grew larger. Palpation in the left half of the epigastrium revealed an irregular, ill-defined swelling, movable on deep respiration. Its location was four fingers above the umbilicus, passing upwards under the left ribs, and was lost in the hepatic dullness on percussion. The resistance can be felt in the median line; the stomach is found 1½ fingers above the umbilicus; there is no dilatation present; acid reaction is not present. It was impossible at that time to decide, with certainty, to which organ this belonged. The patient was admitted on 7th of Feb. and the diagnosis remained uncertain until the 4th of March. During the four weeks there had been rapid emaciation. The author induced the patient to drink a glass of ice water and then examined the contents of the stomach one hour later. It was neutral in reaction and contained a small piece of tissue, which under the microscope was found to consist of small round neucleated cells which were partially arranged in a symmetrical manner, lying close to one another and were apparently held together by connective tissue. Glandular tissue could not be found.

On March 14th, laparotomy was performed. It was found that the greater portion of the stomach was involved in the growth and it was impossible to remove it. The patient died on March 17th.

The autopsy revealed the following: Diffuse glandular enlargement in the omentum. The stomach normal in size, its posterior portion thoroughly united to the liver and spleen. The walls of the stomach were almost universally thickened; its muscular structure almost entirely displaced by brainlike, or gelatinous substance. Numerous nodes on its inner surface seemed about to break down; one of these extending deep through the tissues to the serosa.

Microscopical examinations of these nodes uniformly show them to belong to the round-celled myxo-sarcoma.—(*Centralb. fur Chirurgie*, No. 10, 1894.)

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SIMPLE INTEREST RULES.—Four-per-cent.—Multiply the principal by the number of days to run, separate the right-hand figure from the product, and divide by 9.

Five per cent.—Multiply by number of days and divide by 72.

Six per cent.—Multiply by number of days, separate right-hand figure and divide by 6.

Seven and three-tenths per cent.—Multiply by number of days, and double the amount so obtained. On $100 the interest is just two cents per day.

Eight per cent.—Multiply by number of days and divide by 45.

Nine per cent.—Multiply by number of days, separate right-hand figure, and divide by 4.

Ten per cent.—Multiply by number of days and divide by 36.

Twelve per cent.—Multiply by number of days, separate right-hand figure, and divide by 3.

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AUCTIONEER.—This book, gentlemen, is especially valuable, as it contains marginal notes in the handwriting of Alexander Von Humboldt. A hundred marks offered. Going—going—gone. It is yours sir. (The autograph marginal note by the renowned scholar was as follows: "This book is not worth the paper it is printed on.)"—*Humor-Bacillen.*

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SATURDAY, APRIL 14, 1894.

## EDITORIAL.

### "NO MATTER:" "NEVER MIND."

The intelligent public of this country have of late years noticed, with more or less indifference, the determined efforts of the medical profession to raise the requirements for entering that fellowship to a degree which will effectually prohibit unfit individuals assuming the important responsibilities devolving upon medical practitioners.

The differences of doctors; the bigotry of sectarians; the existence of some code of ethics peculiar to medical men, and of which the laity has no knowledge—'tis true, 'tis pity, and pity 'tis 'tis true, for it is essentially the golden rule, the demonstrations of spectre analyses and the squaring of the circle by medical experts; the colossal fortunes wrung from suffering humanity; the pharisee and the quack—all these and many other phases of medical life were quips mouldy with age when Father Time first heard them in his infancy. Handed down from sire to son, these shadows of jocose shades no longer provoke merriment, and even the most violent convulsions of the funny cartoonist can produce merely a wan smile of pity to find him "reduced to that."

But the public at large as well as scientific men are now invited to witness burlesques of such absolute absurdity and grotesque incongruity that all must perforce smile.

These farces are given under the auspices and personal supervision of the state legislatures of New York and Massachusetts.

Both exhibitions are for the benefit of persons in need of mind cure and seeking a place to apply a remedy. Mind curers, faith healers, *et id genus omne*, under the generic term of Christian Scientists—in every variety and species of this genus christianity and science are the distinguishing characteristics most constantly absent—appear as unfortunates who are clamoring for relief from oppression.

In the New York show, christian scientists appear praying that the existing laws be modified, so that "any person may

freely contract for the services of whomsoever he considers competent to alleviate suffering or prevent or heal disease, and that it shall be lawful for persons so employed to attend, treat, nurse, and endeavor to heal the employing patient, *and receive compensation therefor*, subject to the laws of the State relative to malpractice."

The humor of the situation is enhanced when we see the efforts of apostles of the immaterial to enlighten politicians who regard nothing but what can be made evident to the sense of touch. The latter expectantly listen to the demonstrations of the supremacy of mind over matter; they may conceive of the existence of mind, but evidently are skeptical as to the non-existence of matter or the discussion would abruptly close. They ask the scientist, "What is mind?" and are satisfied with the reply "No matter." Then they ask, "What is matter?" and receive the evasive reply, "Never mind." The philosophy is complete. The herald of the mind triumphant and the practical believer in the substance of things hoped for, have met on a plane common to both, which the prayer of the one and the practice of the other discloses to be—"Never mind." The hilarity of the occasion is sustained throughout by the antics of a prominent ex-member of the judicial bench that, who reaches the logical conclusion in any event, these scientists can do no harm.

The exhibition in the old "Bay State" is more elaborate and refined. When the glories of ancient Athens departed forever, the Genius of the Agora was forced to seek a living elsewhere, and for centuries tramped aimlessly up and down and to and fro upon the earth, until, yielding to the attraction of the magnetic bean-pole, it took up its permanent residence in the hub of the intellectual universe. And to-day the modern Athenians, as did the Attic gossips, "spend their time in nothing else but either to tell or to hear some new thing." In this congenial atmosphere, christian science, with the dignity acquired in the locality, solemnly protests against a bill now pending in the State Legislature. The bill provides for a Board of five examiners, appointed by the Goveanor, which shall issue a license to practice medicine in Massachusetts to all persons "without reputable degrees," on condition that they pass an examination satisfactory to the Board.

Here the interest is centered upon the star comedian. This artist has won laurels in sciences other than christian, but his present role is so unique as to secure the attention of an observer of "this busy world," (*Harper's Weekly*) who say, anent the subject:—

"Among the strongest documents on their (mind-curers) side is a long letter from Dr. William James, the Harvard professor of psychology, who says a number of things that will make lively reading for his colleagues of the medical profession. His objections to the bill are that it is too grandmotherly, and opposed to the best traditions of the State, that 'it adds but an infinitesimal degree of security to the citizens' chances of being faultlessly treated when sick' and that 'it tends to obstruct the progress of therapeutic knowledge.' His argument on his first point is that the proposed bill interferes with personal liberty. On his second point that the best doctors make mistakes, that very many doctors with medical degrees are unfit to practise, and that it is absurd to try to be so particular about doctors anyway, so long as the citizen can buy patent medicines and consume them 'at his unchartered will.' His discourse on his third point takes him into a field in which he is an expert, and is very interesting. He finds that in the treatment of diseases of the nervous system and the mind, power and learning do not necessarily go together. Remarking that the 'great Charcot is accused, and probably, correctly

of actually manufacturing new types of invalidism by his scientific performances at the Salpêtrière, while some common doctor will rescue case after case by using methods which are not medical, but pedagogic and moral,' he goes on to say:

'Of all the new agencies that our day has seen, there is but one that tends steadily to assume a more and more commanding importance, and that is the agency of the patient's mind itself. Whoever can produce effects there holds the key of the situation in a number of morbid conditions of which we do not yet know the extent, for systematic experiments in this direction are in their merest infancy. They began in Europe fifteen years ago, when the medical world so tardily admitted the facts of hypnotism to be true, and in this country they have been carried on in a much bolder and more radical fashion by all those 'mind-curers' and 'christian scientists' with whose results the public, and even the profession, are growing gradually familiar.

'I assuredly hold no brief for any of these healers, and must confess that my intellect has been unable to assimilate their theories, so far as I have heard them given. But their *facts* are patent and startling; and anything that interferes with the multiplication of these facts, and with our freest opportunity of observing and studying them, will, I believe, be a public calamity. The law now proposed will so interfere, simply because the mind-curers will not take the examinations. They return to science disdain for disdain; and nothing would please some of them better than such a taste of imprisonment as might, by the public outcry it would occasion, bring the law rattling down about the ears of the mandarins who should have enacted it.

'And whatever one may think of the narrowness of the mind-curers, their logical position is impregnable. They are proving by the most brilliant new results that the therapeutic relation may be what we can at present describe only as a relation of one person to another person; and they are consistent in resisting to the uttermost any legislation that would make 'examinable' information the root of medical virtue, and hamper the free play of personal force and affinity by mechanically imposed conditions."

An intellect unable to assimilate the theories of mind-curers and yet conclude that their logical position is impregnable may present hyperbole upon hyperbole of psychological excellence, but it lacks common sense. Cases of such metaphysical strabismus are rarely met with in the medical profession of Massachusetts.

To these phantasmagoria a most refreshing contrast is found in the current number of the *Forum*, in which appears a review of medical progress in America by a writer whose brilliancy is not that of insanity and whose opportunity for accurate information as to the status of medical science in this country, both past and present, is equal'ed by few and excelled by none. A condensed abstract of Doctor George F. Shrady's account of "American Achievements in Surgery" will be found in another column.

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**Death of Dr. John H. Rauch.**

John H. Rauch, born September 4, 1828, in Lebanon, Pa., died March 24, 1894, at the home of his brother in the city of his nativity.

He took his doctorate in medicine at the University of Pennsylvania in 1849. In 1850 he settled in Burlington, Iowa. In 1857 he was appointed to the chair of Materia Medica in Rush Medical College, Chicago, which position he filled for three years. He was one of the organizers of the Chicago College of Pharmacy in 1859, where he taught materia medica and medical botany.

During the civil war he was brigade surgeon under General Augur, Assistant-

Medical Director of the Army of the Potomac, and Medical Director of the Gulf Department of the Nineteenth Army Corps. At the close of the war he was breveted Lieutenant-Colonel. Returning to Chicago he assisted in the reorganization of the Health Department of that city, and in 1867 was appointed Sanitary Superintendent.

During his five years of service in this office, the most notable event was the great fire, and upon him devolved the responsibility of organizing and carrying out the sanitary provisions for the great army of homeless citizens. The Illinois State Board of Health was created in 1877, and as one of its members, Dr. Rauch was elected its first president.

It was as an authority on sanitary subjects and as a practical hygienist that Dr. Rauch is best known to the medical world, but in other respects he was a scientist of no mean qualifications. A friend and pupil of Louis Agassiz, and while still living in Iowa, Dr. Rauch investigated and collected scientific material from the upper Missouri and Mississippi rivers for Professor Agassiz, and a report of his work was published in *Sillimans Journal* in 1855. He had previously published a report on the "Medical and Economic Botany of Iowa." Dr. Rauch was likewise the author of numerous monographs on subjects of sanitary science and preventive medicine. His best work as an author will be found in the eight volumes of the Illinois State Board of Health Reports.

Higher medical education owes much to Dr. Rauch. For it was very largely due to the action of the Illinois Board of Health, under the Practice of Medicine Act suggested by him, that medical institutions raised the requirements for graduation and increased the length of their teaching sessions. The general acceptance of the system of requiring a four years' graded course of study preliminary to graduation in medicine, was a crown for hard labor such as is seldom received by the laborer during life. Dr. Rauch was accorded the gratification of knowing while yet alive, that the good he had done would live after him and not be interred with his bones.

# ABSTRACTS.

## AMERICAN ACHIEVEMENTS IN SURGERY.

What may be considered as the first epoch in American surgery was the American discovery of Etherization, which was effected conjointly by Morton, Jackson and Wells. Until that time, almost within the recollection of the older practitioners of the present day, the patient who was the subject of a surgical operation suffered untold tortures of pain during its performance, instead of being, as now, rendered absolutely unconscious during the entire ordeal. When a student, the writer often heard the recitals of the experience of older men who operated before ether was known. The vivid description by Valentine Mott, of the sufferings of the poor victims, would touch the sympathy of the hardest heart. To transform such ordeals of agony into peaceful, dreamless sleep was for American surgery a triumph second to none in the long category of its other brilliant achievements. In fact, it was the starting point of all the subsequent possibilities of almost miraculous ventures.

During the late war of the Rebellion America made her next grand record by notable work upon the battle-field and in the hospital. The major operations performed during that period were commensurate with the vast number of wounded requiring surgical aid. Never before in the history of any war were so many so successfully or promptly cared for. Indeed, after the elaborate records were finished, and the results published, it was

asserted by a leading spirit in the French Academy that America held the surgical scepter of the world. Attesting the truth of this is the remarkable collection of specimens in the Army Medical Museum Washington, which is unequalled in variety and number anywhere on the globe. The elaborate histories of these silently impressive texts established new principles of procedure which were hitherto unknown to the scientific world, and gave American surgery a just recognition for originality of conception, boldness of execution and success of practice. With a training equal to any emergency, while ever ready to adopt and enlarge upon the views of others, she has not been slow in advancing on new lines and securing new triumphs. The aim has been to simplify methods, and thus give them a greater adaptability and a wider practical application. In the treatment of fractures, for instance, this is strikingly manifest in the discarding of cumbersome apparatus and the substitution of simple and more effective ones. There is hardly a bone in the body, which, when broken, has not been beneffited by the American plan of treatment. Notably prominent in this category may be mentioned fracture of the thigh and of the shafts of other long bones. It was reserved for Gurdon Buck, a former surgeon of the New York Hospital, to prove that fractures of the thigh could be most successfully and comfortably adjusted by replacing the complicated harness of straps, stretching-screws, and heavy splint braces, with the simplest form of weight-and-pulley extensions.

The demonstration of the utility of plaster-of-paris splints was likewise made by an American surgeon, the late Dr. James L. Little, who years ago brought it to its present state of perfection. The same principle of fixation was also adopted in an original way by Dr. Lewis A. Sayre, also an American, to the treatment of dis cases and deformities of the spine, by encasing the trunk in a plaster corset. The simplicity and effectiveness of this treatment are now so well established that Sayre's plaster jacket is indorsed by every surgical writer and used by every surgical practitioner. The same may be said of his original tieatment of the collar-bone, and of his methods of extension of hip diseases. The ready adaptability in the American mind to the notable advance in surgery has been shown in the matter of aseptic surgery first advocated by the distinguished Scotch surgeon, Sir Joseph Lister. During a visit to this country in 1876, Lister explained his doctrine, demonstrated its application, and proved its grand results. America was the first to feel the real impulse for good which this discovery made tangible. By its means operations became feasible which before were never dreamed of, and results were obtained which were previously beyond the reach of human endeavor.

Take the advances which have been made in abdominal surgery and for which America can claim no small share of credit. In fact, this country may be said to have originated all the wonderful possibilities connected with this special line of practice. The first one who dared to invade the abdominal region with a knife, and lay bare the vitals, was a Kentucky surgeon, Ephraim McDowell. From the time of the successful performance of that operation in 1809, for the removal of an intra-abdominal tumor a new field was opened for the mitigation of suffering and saving of life, the cultivation of which has prolonged the average human existence several thousand years. The work of McDowell, when its importance was duly appreciated, opened up a new field of practice which has widened into a distinct and almost exclusive department of surgery our work has been fully abreast with that of our transatlantic brethren. In the treatment of internal troubles by instrumentation, many other important discoveries have been made in this country during the past few years. Sims's speculum is known and used throughout Christendom. Another equally famous instrument is Bigelow's lithotrite for crushing vesical calculi, and his ingenious evacua tor for disposing of *debris*. Both of these instruments so revolutionized the old system of practice in the particular lines for which they are adapted that nothing now takes the place of the American contrivances. It is within a very short period that O'Dwyer's intubation tubes for the treatment of suffocative croup put in their claim far recognition, but they are now almost universally used in all the class of cases for which they are so eminently suitable.—*Dr. George F. Shrady, in the Forum for April.*

# SOCIETY REPORTS.

## THE LOUISVILLE CLINICAL SOCIETY.

*January 30th, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### CASE OF ACCIDENTAL HERNIA.

DR. P. GUNTERMANN: The case I am going to report is one which is very peculiar. It shows how quickly a person may be taken deathly sick; it shows also if the nature of the trouble is not recognized, how seriously it may reflect upon the character of the attending physician. I was called about a week ago, at midnight, to see a young man seventeen years of age, who was reported to be suffering from "cramp of the stomach." When I saw the patient I learned that he had recently gone through an attack of typhoid fever, making a very slow and tedious recovery. He had finally recovered, and for a few weeks had been in ordinarily good health. The evening I was called he had eaten a hearty supper; he attended school that night and came home feeling perfectly well. He went to bed and soon after was taken with violent pain in the stomach; directly he began to vomit and purge. His people, thinking it was an ordinary attack of something like cholera morbus, made hot applications, gave him hot whisky, etc. He continued to grow worse, and at twelve o'clock I was called in. I found him suffering with intense pain, which he located at about the pit of the stomach. I asked him if he had a rupture or ever had one, and he said, "No." I thought my first business was to relieve his intense sufferings. He had vomited a great deal and purged several times, so that the stomach and bowels must have been well emptied, and I did not think it necessary to relieve him in that way. I gave him a hypodermatic injection of ¼ grain of morphine with 1-150 grain atrophine, and then made a careful examination of his abdomen, but could discover nothing wrong. I then sat down to write a prescription, and while doing this he commenced vomiting again, and had a frightful retching attack. When this was over he said, "Oh, Doctor, there is a bone coming out of my side." I went to him and found in the left inguinal space a rupture as large as my fist. With some little difficulty it was reduced, and the pain subsided. With the reduction of the hernia, not only did pain subside in that location, but there was also entire disappearance of the pain about the stomach, and the other symptoms. I thought at the time that possibly the vomiting and the diarrhœa were influenced by a partial rupture, that the bowel had entered the internal ring, then during the last effort of vomiting it had made its exit, and after it was reduced every symptom of vomiting and purging subsided. The next day I sent the patient to a truss-maker to have a truss adjusted, and he has not had an untoward symptom since.

I want to say that if I had left the patient perhaps two minutes sooner; if the pain had not been very severe; if he had not noticed the rupture protruding at the time, by the next morning it might have developed into a very serious case of rupture, requiring an operation or some other radical measure, and the result might have been a serious reflection upon my diagnosis of his condition.

#### DISCUSSION

DR. W. H. WATHEN: Had the patient ever observed any indications of hernia preceding this attack?

DR. P. GUNTERMANN: There was not the slightest sign of a hernia until the last violent attack of retching, when it simply popped out.

DR. W. H. WATHEN: The case is very interesting, and it is now easy to understand what caused the vomiting and diarrhœa. A part of the bowel had become constricted in the internal ring, causing these troubles which the Doctor has described. Such symptoms are common in hernial protrusions. The strain produced by retching forced more of the bowel into the sac, and dilated it to such an extent as to make it perceptible both to the patient and physician; but I am inclined to the opinion that this man, if the case could be looked into carefully had a hernia before, for the reason that the sac would have been so small that I do not think it could have been enlarged so suddenly to the extent Dr. Guntermann states. We often fail to get the accurate history of troubles of this sort from patients.

DR. J. W. IRWIN: It seems to me that the pain, vomiting, and diarrhœa were all due to irritation of the bowels, and that it was a hernia from the beginning. I do not see any positive reason why the first rupture may not be large. Generally speaking they are not large, but I have seen some ruptures with history pointing clearly to that condition that were as large as a man's fist at first. But

Dr. Guntermann's report of the case shows how careful we should be in diagnosticating the cause of pain in the bowels and vomiting, in some cases.

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GASTRIC ULCER.

DR. J. M. KRIM: Mr. V. S., aged fifty-two years; married; occupation florist; family history good; had never been sick since childhood. He commenced complaining about the middle of January, 1892, with pain in the stomach and back, which came on at intervals of two to four days; constipation marked; appetite good. This condition of affairs lasted for about two months, when pain came on at shorter intervals, more severe in character; food was vomited shortly after eating. There was loss of sleep and appetite, and loss of flesh, about ten pounds in six weeks. He had taken various remedies without benefit.

Patient consulted me early in April. Examination revealed the following: Condition very anæmic; skin flabby; pulse 90 and weak; respiration 25; temperature normal; urine normal; constipation; tired feeling, not able to work; insomnia; dull aching pain, with burning sensation in the epigastrium; pain more intense on pressure, a little to the right of the median line; stomach enlarged, pain more severe after eating, with some relief after vomiting of food; considerable thirst. Diagnosis: Gastric ulcer.

I placed him on bismuth and chloroform mixture (bismuth subnit. grs. xx, chloroform gtt. x, water $f\overline{3}ss$) to be taken every two hours until there was some relief; ordered absolute rest, with milk diet. I was called in haste about six o'clock in the evening and found the patient almost pulseless, very pale, scracely breathing, extremities cold and vomiting large quantities of blood. I applied ice to the stomach and gave it freely by the mouth. I also injected three grains of ergotin, whiskey, and aromatic spirits of ammonia, which was repeated as indicated, using warmth to the extremities. Patient rallied after eight hours of hard work, hæmatemesis ceased and he rested comfortably. The following day he had a copious tarry-looking evacuation, pulse good, no pain. The bismuth and chloroform mixture was continued and an enema was given to cleanse the bowel for rectal feeding (peptonized milk and beef). The patient did well for four days, when he had another small hemorrhage which was easily controlled. Rectal feeding and the mixture were continued. On the third day after this I resorted to stomach washing with chloroform water ($f\overline{3}j$ to Oj, twice a day for a week, then once a day for two weeks), which made the patient feel very comfortable, and continued the mixture every three to four hours, allowing small quantities of peptonized milk and beef, which was relished. Rectal feeding was discontinued and the patient kept on liquid food exclusively for three weeks, then allowed small quantities of solid food, which gave him no discomfort. He was put upon reconstructives and made a slow but uneventful recovery, gaining flesh and good color. He was under my care about three months then, having removed to tpe country. I heard no more of him until in August, 1893, when he informed me that he had been entirely well until about two months before, at which time he began to feel badly and being advised by friends to go to some watering place in Germany, he came to ask my advice. I readily approved and he left the following week, remaining abroad about two and one-half months at various watering places.

After his return I was very much astonished to note his decided emaciation and generally unfavorable appearance. He informed me that he had consulted Ewald and various other prominent practitioners abroad without any relief. He received no treatment after his return. On December 2d, 1893, he had a severe hemorrhage and died before I reached his residence.

Autopsy revealed the following: Stomach contained about a half-pint of blood; there was considerable narrowing of the pyloric orifice. About two and one-half inches from the pylorus, on the anterior surface, there was a stellar cicatrix one-half inch in length by three-quarters inch in width, with hardened edges and involving the muscular coat. At the cardiac end there was a soft mass two inches long by one inch wide, projecting about one-quarter inch above the mucous surface. In the centre of this was an irregular, apparently recent, ulcer, about one-quarter inch in diameter, in the centre of which was a small perforation. I removed a piece of the mass, had it examined, and was informed that it was a medullary cancer.

I used Hofrath Stepps' idea in regard to the cloroform and bismuth mixture. He claims that ulcers heal more rapidly under this treatment than by any other method he has tried, having had some four years' experience with the mixture.

DISCUSSION.

DR. J. W. IRWIN: The case detailed by Dr. Krim is an interesting one, and if a microscopical examination had been made it would have been still more interesting. The diagnosis in the main was correct, but the treatment of the case was less judicious in that solid food was resumed by the patient too soon. The cause of the ulcer seems to have been malignant disease of the stomach, and that was possibly the cause of the narrowing

of the pylorus. It has been my experience that gastric ulcers, even when not complicated by malignant growths or malignant formations, do not heal in three weeks or three months. It takes a much longer time. When I have seen such cases, and I have not seen a great many, I have advised the patients to remain under treatment—and very little treatment at that other than a regulation of the diet, clothing, attention to their environments, etc.—for a period of at least eighteen months before what would be called a permanent cure of these disorders can be affected.

A patient having a simple gastric ulcer came under my care six or eight years ago. The ulcer had been in existence then three years, but was not diagnosticated until after I saw the case. The patient, a lady, was very much emaciated and feeble. I sent her to the Norton Infirmary where she remained six weeks. Her diet consisted of very limited quantities of milk and cream. A satisfactory diagnosis of the case was established and she was put on the way toward recovery, When she came under my care she had frequent small hemorrhages, every time she partook of solid food it was ejected mixed with blood. The blood vomited was usually darkened by the action of the gastric juice, From the time she began to use the cream diet she had no more hemorrhages, and in the six weeks she remained in the infirmary she gained six pounds in weight. I advised that she continue the use of the milk and cream diet, the quantity to be gradually increased until it reached three and one-half quarts of milk per day. I suggested that to this quantity of milk she might add one pint of cream. She followed the advice given her for eight months, and did not depart from the instructions to avoid taking any solid food. At the end of that time, a relative visited the family and persuaded her that dieting was all nonsense and that she was starving herself to death, although she had then gained eighteen pounds in weight. This relative urged her to partake of the elaborate dinner that had been served in his honor, and she did so. In less than a half hour after eating, she became nauseated and vomited the food and about a pint of blood. She was greatly prostrated as a great deal of blood passed from the stomach into the intestines as was shown by a subsequent evacuation of the bowels. She came to Louisville on the following day and reported what she had done. I advised that she continue the milk diet. Once, about six months afterward, she ate two crackers, which was followed by vomiting mixed with blood. She then concluded that she would not again use anything but milk. While using milk and cream she had no vomiting at all I gave her no medicine of any kind. The bowel became constipated by the use of the milk and was relieved by large enemata of tepid water. She continued the milk diet for eighteen months, I then advised her to take very small quantities of baker's bread to begin with, gradually increasing the quantity, still keeping up the use of milk and cream. She had no more vomiting and no more pain after the use of food. The regular diet of mixed food, such as she had been in the habit of using before, was gradually resumed and there has been no return of the gastric ulcer in six or seven years. I heard from her a day or two ago, she is very strong and well and has gained forty-three pounds in weight from the time she first came under my care.

This case illustrates all the other cases of gastric ulcer pure and simple I have not seen a case of gastric ulcer get well in so short a time as three weeks or three months. If I understood the essayist correctly, after three weeks treatment he allowed his patient to take solid food. The point I want to make is that if it was a gastric ulcer pure and simple, the patient was ordered to resume solid food too soon. As it was, it did not make much difference, as the trouble was malignant and not a simple ulcer. Every case that I have seen unattended by malignancy, I have always considered it wise to keep under dietetic measures for about eighteen months before I could hope for a cure.

DR. P. GUNTERMANN: I have seen several cases which I thought were gastric ulcer; some of them died in the course of due time and two of them recovered. These two cases I treated by rectal feeding altogether for quite a while, then commenced gradually with liquid foods. I first gave milk diluted with lime water, making it as alkaline as possible, I gave no medicine to speak of. Some morphine was given hypodermatically for the relief of pain and, to assist the healing process, I have given lime water and carbolic acid, which I regard as one of the best antiemetic remedies that can be used.

I had one case that I diagnosticated as gastric ulcer and treated for a while; the man gained in weight: he had become strong, able to follow his occupation and my visits ceased. After a few months I was called to see him at his home. He was then quite ill; he vomited all the food taken into the stomach and had several times vomited blood. He had intermittent pain, not the continuous sharp pain that usually attends gastric ulcers. I then became a little dubious as to the nature of the trouble. Vomiting and pain continued, and in the course of time he died. I had an opportunity to make a *post-mortem* examination, and found the pylorus complete closed by an indurated mass as large as a child's head.

I do not think dilatation of the stomach is usually present in gastric ulcers. I do not believe it is according to the teaching of the best authorities to wash out the stomach in gastric ulcer.

DR. T. P. SATTERWHITE: The foregoing remarks recall to mind two cases which occured in my practice several years ago. The first was a German lady; when I saw her she was greatly emaciated, had all the appearance of cancerous cachexia, was unable to retain food, but there was no vomiting of blood. She was under my care for twelve months. I put her upon equal portions of milk and Carlsbad water and she was entirely relieved with that treatment alone. When the Carlsbad would act too freely, we substituted Vichy. She grew to be as stout as she ever was, weighing about 160 pounds.

The other case was a man who was treated in the same way at the St. Mary & Elizabeth Infirmary, he gained some flesh, and was sufficiently improved to be sent home. He died some time afterward, however, and like the case reported by Dr. Guntermann, *post mortem* examination revealed a cancerous condition of the pylorus.

DR. J. M. KRIM: The case referred to in my paper did not get well in three weeks by any means. I kept him on a liquid diet for three weeks, then allowed him a small quantity of solid food, which did not appear to give any discomfort, The stomach washing with chloroform and water was carefully carried out according to the idea of Steeps, who has had quite an extensive experience in the treatment of gastric ulcer. The chloroform and bismuth mixture is also recommended by Steeps; he claims that healing of the ulcer takes place much more rapidly under treatment by this mixture than anything else he has tried. The patient was under my care about three months, then he moved to the country; he gained in flesh while he was under treatment. I washed the stomach for about four weeks, twice a day for the first week, and after that once a day. As solid food in very limited quantities gave him no inconvenience, it was allowed, but the milk diet was continued.

Dr. Irwin evidently did not understand me correctly. I stated in my paper that the patient first commenced to complain in January, 1892, and consulted me in April of the same year. He was under my care about three months, then removed to the country and I saw no more of him until April, 1893, when he simply consulted me in reference to the advisability of his taking a trip abroad. I did not prescribe for him at this time, and he received no treatment after he returned from Germany. I was called hurriedly to see the patient, early in December, but he died before I reached him.

I firmly believe that the first trouble was simple gastric ulcer, which was entirely relieved by the treatment as stated in my report. But when he consulted me on the second occassion (in August, 1893) at the time he went to Europe, I believe the condition was cancerous. In other words the primary condition was that of a simple ulcer, and the cancerous trouble which developed later was secondary.

No history was obtained prior to the first appearance of pain (January, 1892) except that the man had always been in perfectly good health.

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### SARCOMA OF THE TIBIA—AMPUTATION—RECURRENCE OF THE GBOWTH IN THE PERICRANIUM OVER THE PARIETAL BONE—REMOVAL —RECURRENCE.

DR. W. O. ROBERTS: I saw with Dr. Krim in December, 1898, a girl, seventeen years of age, who six months previously had her right limb amputated above the knee because of sarcomatous disease of the tibia. The wound healed nicely and she had no further trouble until November 1893, when she received, as the result of a fall, a slight bruise on the side of the head, which, however did not seem at all serious. In the course of ten days after receipt of the injury to her head, a lump began to make its appearanee. At the end of six weeks, when I saw the patient, there was a tumor as large as a man's fist situated on the left side of the head over the parietal bone. She had some numbness of the right arm and the stump of her right limb. Dr. Krim had aspirated the tumor, but nothing was secured save a little blood. We were satisfied before any operative interference was undertaken, that the growth was a sarcoma, starting, as we thought, in the pericranium. We advised operation as the only chance of prolonging life, and in the early part of December I operated at the Norton Infirmary. After having shaved the entire scalp, I made a horse-shoe flap and exposed the growth and, as we had suspected, it started from the pericranium, After removing the growth as we thought entirely, we scraped the bone which contained a carious spot, at about the size of a silver quarter, due evidently to pressure, and replaced the flap. The wound healed by first intention throughout its entire extent. The girl was sent home then, and after remaining entirely well for three weeks, the growth has recurred in about the same locality and is now developipg very rapidly; it has already attained the size it was at the time of the operation in December.

Under the microscope the growth was found to be a small round cell sarcoma.

GUAIACOL FOR REDUCTION OF TEMPERATURE.

DR. J. W. IRWIN: Some days ago I saw an account of a remedy for the reduction of the temperature in typhoid fever, which is to be applied locally. The article was a lecture delivered in the Pennsylvania Hospital by Dr. Da Costa, of Philadelphia. He reported a case of typhoid fever as a type of the disease that he had treatedby means of guaiacol. I had a case of typhoid fever, thirteen days sick, and in which the temperature was ranging from 103° F. in the morning, tn 104.°5 F. in the evening. Sponging thoroughly with cold water, ammonia, etc. several times a day did not keep the temperature below 103° F. Dr. Da Costa used in such cases guaiacol over the iliac region, applying it with a camels hair brush and then had it thoroughly rubbed in by the hand of the nurse, for from five to fifteen minutes, until the skin became saturated with it. The skin had previously been cleansed with soap and water. Then a dressing of wax paper was applied so as to hold it as long as possible in contact with the skin. He raised only one objection to its use and that was its odor. The best thing which he found to disguise the odor was oil of cloves. This I used, but the odor of the guaiacol was still quite pronounced. The application was made yesterday morning at ten o'clock. There was no change in the temperature until about eleven o'clock. When the application was made at ten o'clock the temperature was 103°F., at eleven oclock it had fallen to 101°F. At twelve o'clock it was found to be 97.5°F. and at two o'clock in the afternoon 96.5°F. There was no nervous depression whatever; there was no material change in the pulse, if any thing it grew stronger. The patient felt cheerful. The temperature remained 96.5° to 101 F. until ten o'clock at night. At three o'clock in the morning the temperature again went up to 104° F. rather suddenly. Guaiacol was again applied and an hour afterward the temperature was reduced to 98° F. and did not go above 98° F. until ten o'clock the next day. It has not been above 101° F. since that time. Two applications of guaiacol have controlled the fever in this case for twenty-six hours. How it acted I cannot tell. Dr. Da Costa thinks that it is absorbed by the skin and then finds its way to the centers which control the heat. The quantity of guaiacol used was thirty drops at each time. The author recommends thirty drops as the maximum quantity for each application, but he has used sixty drops with the result of producing too much depression of the temperature. He has used it in tuberculosis of the lungs and catarrhal pneumonia, with less effect than in typhoid fever, the temperature falling two or three degrees. He has also used it in malarial fever where the temperature went up to 104° F. and the reduction was very pronounced, it falling, if I remember correctly, to 93° F.—in this case he used from forty to sixty drops But he thought in cases where the temperature did not go above 102° or 103° F. that twenty drops would be enough. He was led to resort to this treatment, not because he disapproved of the water treatment, such as the cold bath, wet sheet, or sponging, but because he believed it to be one of the most important agents for the reduction of temperature in certain forms of typhoid fever. The water treatment, he says, has its disadvantages as moving the patient tends to produce hemorrhages of the bowels and in other ways the patient is often made worse by the bath by reason of the fact that he is not able to be moved under certain well-known conditions. In those cases where it would not be advisable to resort to the bath or wet sheet, he recommends the use of guaiacol. He thinks as a local remedy the possibilities for guaiacol are very great, although he has not yet used it in a sufficient number of cases to determine definitely. He says that guaiacol prevents the return of the high temperature very much longer than the water treatment, this of course is in favor of guaiacol as against the cold bath, wet sheet or pack. The observation I have made in this single instance is most gratifying to me and it fully agrees with the observations of so eminent authority as Dr. J. M. DaCosta.

DISCUSSION.

DR. T. P. SATTERWHITE: Would not it be better to commence with say fifteen or twenty drops of guaiacol and then increase the quantity if necessary?

DR. J. W. IRWIN: Even the reduction of temperature to 96° 5°F. in the case I have reported, was not attended by any signs of depression whatever. The pulse was not changed except that it became a little fuller and stronger. The pulse was 108 at the time the first application of guaiacol was made. The prescription was thirty drops of guaiacol and five drops of oil of cloves.

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SUPER-FŒTATION.

DR. W. H. WATHEN: I recently attended a woman in an abortion where conception occurred in a womb containing a large fleshy mole. Two years ago, this woman placed herself under treatment for retro-version of the womb, with great enlargement, but with no adhesions or disease of the adnexa. The womb was very easily replaced in its natural position and held there by a pessary which gave relief. She became pregnant and the pessary was removed at the end of the third month. The womb then remained in position and continued to enlarge until it was the size of a three and one-half months pregnant

womb. It grew no larger and then began decreasing in size, and in six weeks had returned to its retroplaced position. Hemorrhage then began and continued for a week or ten days, when I was called to see her. She was suffering severe pain and the bleeding was profuse. The neck of the womb was dilated sufficiently to admit my finger, and I could feel a solid mass but no fœtus. The vagina was thoroughly cleansed and with a forceps I removed a fleshy mole about the size of a turkey's egg. The os uteri was imperfectly dilated, and the mole was taken away in several pieces. She recovered from the abortion and the womb was again held in place by a pessary. She menstruated regularly until about ten months ago, when she again consulted me, having all the symptoms of pregnancy. The womb continued to enlarge and at the end of three months the pessary was not needed to hold the organ in position.

At the beginning of the fourth month she had hemorrhage which continued for nearly a month. I now found that the womb had grown considerably smaller, and had again become retroverted. After a few weeks she menstruated and was regular for two months, when she again missed her menses for three months. Her womb enlarged and could be felt above the pelvis. She began bleeding again, and the womb grew smaller. The hemorrhage continued for three weeks, when her husband came for me stating that his wife was flooding and suffering severely. I found she had aborted, the embryo being about seven to nine weeks developed and in a state of decided decomposition, and the odor very offensive. The decidual membranes were removed and having cleansed her thoroughly, I expected no further trouble. Two days afterward her husband came for me and said that his wife was suffering intense pain. Before I reached the house she had expelled a hard, fleshy mole about the size of a turkey's egg, showing no signs of decomposition and having no odor, convincing me that I was correct about the first pregnancy, The embryo having died, the fluid was absorbed, and the membranes developed into a fleshy mole. The second pregnancy resulted, the embryo finally died and was expelled. The last abortion was about two months ago and the woman has recovered nicely.

DISCUSSION.

DR. T. P. SATTERWHITE: I would like to inquire if there was any menorrhagia, and what Dr. Wathen proposes to do in the case.

DR. W. H. WATHEN: There was no menorrhagia; the periods were normal. It is best to perform some kind of operation to hold the womb in position. I do not think the Alexander operation would do any good because the uterus is so large that it would stretch the round ligaments and again become retroverted. I do not believe she will consent to any operation, but I would recommend anterior ventral fixation, having first thoroughly curetted the womb and tamponed it with iodoform gauze.

DR. P. GUNTERMANN: I would like to know why, when this woman had the second abortion, and you did not find anything coming away, you did not look for that which ought to come away, the membranes, etc.

DR. W. H. WATHEN: At the second abortion the decidual membranes came away, and were so decomposed that the odor was very offensive. The placenta is very small at seven or eight weeks.

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### The Treatment of Whooping-Cough by Bromoform.

According to the *Revue Internationale de Bibliigraphie Medicale*, Pelicer has employed bromoform with very good results in the treatment of this obstinate affection. It is a colorless liquid, produced by the action of bromine on alcohol in the presence of a base. When administered to animals by inhalation or hypodermic injection, it produces narcosis, without greatly disturbing the respiration or circulation. The dose is 1 drop for each year of the patient, given four times a day, but this dose should be increased progressively until it is taken many times a day. He has given as much as 48 drops a day during six days to a child of two years, but after this dosage he observed a general erythema, but no diarrhœa. There was increased frequency of the pulse and respiration. Bromoform diminishes the number of the attacks and their duration. Under its influence the vomiting ceases and the appetite returns. It is to be employed during a period of two or three weeks. In a number of cases he used it even longer than this.

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### Exclusion of Daylight in the Treatment of Small-pox.

Finsen (*Hosp. Tid.*, No. 27, 1893) has made some observations on the effect of light on the skin. He referred to the good results obtained by Black and others by the exclusion of daylight in the treatment of small-pox, but argued that, as Widmark has shown that it is the ulta-violet rays which have the strong chemical action, it is not necessary to exclude the daylight, but by using red curtains tightly drawn or red window-panes, the injurious effects of the light can be prevented. The correctness of this hypothesis was proved by Svendsen, of Bergen, who last summer treated four cases of small-pox in unvaccinated patients by covering the windows with thick red wollen curtains. The patients escaped the suppurative stage; there was no rise of temperature, no œdema. The patients passed from the vesicular stage, which was slightly prolonged, into convalescence, and escaped scarring.—*British Medical Journal*, February 17, 1894.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE BUFFALO MEDICAL AND SURGICAL JOURNAL

for April, contains an editorial showing the result of changing the water supply from the Niagara river to the inlet, communicating with the harbor, and pumping from an old unused reservoir. This was done during the month of February, and during the first week of March two-hundred new cases of typhoid fever were reported, while previous to this date the number reported conformed to that of other years.

A significant fact is, that one part of the city escaped with only one case, and that part had the same variety of inhabitants, homes, manner of living, etc., as the rest of the city except that its water supply was independent and came from natural springs.

In the same journal Dr. James F. W. Ross reports a case of

**Suppurating Myoma of the Uterine Wall.**

for which he operated five weeks after confinement. The growth proved to be an intramural fibroid, about the size of a child's head, and left a very perceptible cavity in the uterine wall, palpable through the abdomen.

The case is reported because the wall at the point of attachment, extending from the fundus to the internal os, was left so exceedingly thin that it did not seem possible that pregnancy could terminate naturally at any future time, and the author has lately heard of the safe delivery of twins.

Dr. I: N. Love writes about

**Neurasthenia,**

which he believes to be a term often misapplied, and thinks nerve weariness is quite different from nerve exhaustion, and generally due to over eating and constipation; perhaps, combined with anxiety and laziness. Proper regulation of the diet, free purgation for a week or so, properly graded exercise, a greater supply of fresh air, and possibly the relief of peripheral irritation, would, the author, thinks, cure many attacks of so-called nervous exhaustion.

Dr. Herman Mynter gives some clinical reports of very interesting cases which have required

**Trephining.**

In one he was able to replace a one-and-one quarter inch circle of bone, and in several he placed irregular fragments in the opening, and prevented thereby the union of scalp and dura mater, suppuration compelling the removal of these nuclei in only one instance.

On several occasions the author attempted the use of gold leaf to close the opening in the skull, but irritation and pain always forced its removal; plates of celluloid were free from this objection.

The author considers the use of antiseptics, even in exceedingly weak solution, very objectionable in brain surgery. Sterilized water, has in his experience given perfect satisfaction, whereas, the chemical solutions did not.

The cases cited comprise subdural hemorrhage with aphasia and paresis, abscess of the brain, and traumatic epilepsy; all ended in recovery both from the operation, and the cause of the operation.

Dr. Edward B. Angell reports the result of an autopsy on a woman of thirty-four years, who when five years old suffered a

**Sudden Right Hemiplegia During Convalescence from Scarlet Fever.**

Recovery occurred from the hemipleyia, but the right arm and hand never fully developed. Two and one half years before her death symptoms of cerebellar tumor appeared, but no operation was performed.

The autopsy revealed an encapsulated gliosarcoma two ounces in weight, spherical, lying between the right cerebellar hemisphere, the right temporosphenoidal, and the occipital lobes, and pressing on the corpora quadrigemina.

The right crus cerebri, the pons, and the medulla were pressed on by the growth. The left cerebral hemisphere contained a large cyst, the sequel of the trouble in childhood, and was one-fifth smaller than its fellow, while the right side seemed to have the convolutions, sulci and gray matter all developed, to take the place of the deformed left.

The right cerebellum was in keeping with the left cerebral hemisphere, confirming the theory of their development in unison.

The author describes also, the gradual learning to speak again, and the failure to develop the muscular system so as to dance, or even run easily.

IN THE JOURNAL OF NERVOUS AND MENTAL DISEASES

for March, Dr. E. M. Green reports a case of

**Hysterectomy for Procidentia.**

The patient was fifty years of age, the subject of chronic mania, and had been in the asylum for ten years. During all of this time she was noisy, filthy, destructive, and even by the use of hypnotics obtained only a few hours' sleep.

She had suffered for some time from complete prolapse of the uterus, had a cystocele and rectocele and suffered much from loss of blood from vaginal ulcers.

Attempts to return the uterus and keep it in position failed on account of the patient's interference; hysterectomy was performed, therefore, under very unfavorable conditions, but the patient nevertheless was up at the end of six weeks looking much better.

In about two months her habits and mental condition began a rapid improvement. No recurrence of cystocele or rectocele took place, and the author states that she is now a well behaved patient and has not required a hypnotic for about five months.

In the same number Scheinmann is quoted from the *Berl. Klin Wochensch.*, stating that a common, and often unsuspected, cause of persistent headache is some nasal trouble, which being relieved puts an end to the headache.

He declares headache to be frequently the only early symptom of severe nasal disorders, that the demonstration of nasal origin permits a favorable prognosis, that in all cases of headache of unknown origin careful examination of the nose is required, and that the extistence of neurasthenia does not exclude a local cause for the headache.

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IN THE SANITARIAN

for March, is an article by Fraenkel (from the *Deut. Med. Woch.*) relative to the

**Effect of Thymus Cultures of Eberts' Bacillus,**

rendering animals free from infection by this disease. Fifty-seven cases of typhoid fever in man were treated as follows: Thymus cultures, proved to be sterile by experiment, were heated to 63° (R.) and 0.5 c. c. injected into the iliac region, (afterward the glutei were found preferable).

No change was noted on the first day; on the second the dose was doubled, and caused rise of temperature and shivering. On the third day the temperature fell, and again on the fourth; but if the treatment were not confined it would now rise. The temperature was used as the guide for treatment, and when there was no rise, injections were given at intervals of two days, an increase of 1 c. c. being made each time. The fever became intermittent, and in a short time there was a pyrexia. With the fall there was profuse diuresis and sweating, and a lessening of the diarrhœa.

The patients seemed convalescent, while still having enlarged spleen and the rose-colored spots, and fourteen or sixteen days after defervescence were able to be up. The treatment was successful in relapses, and produced a uniformity and rapid improvement, not to be obtained by other means.

To settle the question of sterilized culture of micro-organisms, having no connection with the disease, favorably affecting its course, a few were tried, and seemed again to act favorably. The culture medium was prepared from the thymus here also.

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THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

for April, contains an interesting paper by Dr. J. M. DaCosta, on

**Cardiac Asthenia, or Heart-Exhaustion,**

meaning by this that condition in which there is for a long period habitual feeble action of the heart, and where this constitutes the essential and only appreciable disorder. This heart-feebleness or heart-exhaustion comes, he says, from two causes: it is due either to nervous failure or to a weak heart muscle; in some instances to a combination of both.

The affection generally manifests itself in those whose nervous system has been strained by worry or overwork. It shows itself frequently by a veritable and sudden cardiac collapse, though the causes that have led to this become apparent enough when inquired into, and there have been warning signs. The patient is obliged to stay in bed; all attempts at sitting up produce a sense of swooning and vanishing pulse, or there is actual fainting from time to time. The heart's action is feeble, the pulse is very small and compressible, and generally increased in frequency; there is a sense of uneasiness in the cardiac region, but very rarely actual pain; the extremities and the nose and ears are cold; the general temperature is below the normal. The capillary circulation is poor, the skin pale, occasionally injected or flushed; sweating is the exception. The breathing is conspicuously unaltered, although there may be a sense of oppression. The reflexes are unimpaired or sluggish. The appetite is poor, though there are no marked gastric symptoms; the bowels are constipated. Insomnia may be complained of; apprehension and low spiritis are very common. From this state of depression and disturbed circulation the patient rallies but slowly. It is one or two months before he can sit up without inclination to faintness, and months more before he recovers. The course of the disease is as markedly chronic as the onset has been markedly rapid.

The heart's action is mostly accelerated, but not irregular. It is very variable, always rises markedly after meals, and is influenced by the slightest exertion. The physical signs of the heart disorder are very significant. There is no increased percussion dullness, the impulse is feeble, difficult to find, not diffuse. The first sound is short, lacking in volume, and may be obscure or short and valvular; the second is not accentuated. Rarely there may be functional apex murmurs of dynamic origin, and these murmurs may be brought out by suddenly closing the hand tightly. A sensitiveness to touch in the cardiac region is at times noticed.

The author is inclined to attribute the cardiac weakness more immediately to disturbances in the cardiac ganglia than in the centres in the medulla and to the disordered inhibitory influence of the vagus, though he grants that the central nervous system is affected.

In the asthenic nervous heart the prognosis is good. Under treatment and in time they all recover. While there is danger from so-called heart failure the author has never met with an instance. With a heart weak from muscular weakness the same is not true, the author reporting a case in which with only a very moderate amount of bronchitis, a sudden and unlooked-for fatal collapse occurred.

For the cases of the asthenic weak heart, rest in bed is essential, and when the patients are able to sit up, nothing does as much good as graduated shower baths. Massage is useful at a later stage of treatment. Where the weak heart depends on muscular weakness, massage and Swedish movements can be resorted to from the beginning. From Swedish movements that are especially adapted to promote the flow of blood and to strengthen the heart, the author has seen great good. The food should always be as nutritious as possible, taken as frequently and in amount as large as the digestion will tolerate, and stimulants have often to be resorted to. The tendency to constipation should be remedied by diet and light laxatives.

Among drugs strychnine stands pre-eminent. It should be given in doses of one-thirtieth of a grain, three times a day, and continued for some time. Iron is only needed to combat any complicating anæmia and its tendency to constipate makes it a remedy of doubtful advantage. Arsenic in the nervous heart comes next to strychnia. Its action cannot be explained by its removing anæmia, for it proves to be valuable where the blood-count shows this not to exist. Of the so-called heart tonics, digitalis is the best, but it is not the certain remedy that might be supposed. When it is used the patient should be kept in bed. Adonidin and chloride of barium have been of good service at times; cactus and convalaria have been disappointing. Caffiene and cocaine are both valuable, but their action cannot be kept up; from cocaine there is the danger of establishing the cocaine habit. It is, however, very serviceable during urgent symptoms of failing heart. Nitroglycerin is not of much avail, except there be cardiac pain, or in combination with remedies like digitalis, which act more distinctly on the force of the heart. Bromides, valerian, and opium ought to be left to meet certain special indications of nervous disturbance.

In the paper is the report of several cases of this interesting condition observed by the author.

Dr. Charles W. Allen contributes a paper on

**Syphilis of the Epididymis.**

The epididymis, according to the author's observations, is capable of suffering by itself, and not infrequently is affected independently of the testis proper, not only in the early consecutive period of syphilis, but in all stages of the disease and sometimes quite late. In what is termed commonly syphilitic testicle, the epididymis is affected in perhaps one-third of the cases, and the possibility of the organ remaining enlarged after a mild grade of orchitis which has disappeared should be remembered to obviate a possible source of error in diagnosis. The early diffuse syphilis of the epididymis, or syphilitic epididymitis proper, is usually confined to the globus major, though cases have been reported in which the tail alone has been inflamed, and often the body suffers too. The enlargement may be either rounded or irregularly square or angular, and often not much larger than an American chestnut. There appears to be a decided tendency for both epididymes to suffer coincidently or one after the other. If other diagnostic features are not sufficient, the fact that the infiltration entirely and quite promptly disappears under anti-syphilitic treatment makes its nature clear. Sequellæ are usually absent, while after gonorrhœal epididymitis fibrious remains are apt to show themselves for a long time, especially about the tail.

The author cautions however, that a slight improvement under the iodides must not have too much weight given to it, as the same temporary improvement may take place in tuberculosis of the epididymis. Where fibrous changes have taken place we cannot hope for a return to normal form and size; and when pressure has been exerted, surrounding, and perhaps parenchymatous deposits may result; but, aside from such changes, the iodides should affect a cure.

Several cases are reported by the author.

William Thomas Corlett, M. D., L. R. C. P., Lond., discusses

**Pemphigus:**

its clinical varieties and treatment. In the treatment he states that he has never observed the slightest benefit from arsenic and he is forced to the conclusion that as yet we have no trustworthy specific for pemphigus. The internal treatment should be conducted along the lines of general therapeutics. Food should be selected which is easily digested, although possessing the proper elements for proper nutrition, such as milk, eggs, &c. In pemphigus, above all diseases, tonics are indicated. Iron and arsenic, the latter in small tonic doses, and, in selected cases, cod-liver oil, will afford the best means at command. Locally the general hygienic environment should be looked after, fresh air and sunlight should never be forgotten, and, in an epidemic, isolation and disinfection, such as recommended for smallpox and erysipelas. Then the blebs should be punctured and the sac washed out with some bland disinfectant, such as the saturated solution of boric acid. This is followed by some application of a bland, soothing nature. The author finds the continuous water bath in use in Germany, of great service but difficult of application in private practice. Of lotions, the glycerole of tannin has given the most marked benefit. It may be used in the strength of one part of the glycerole of tannin to three of distilled hamamelis or water. This strength may be increased to equal parts of the glycerole of tannin and camphor-water. When the eruption is limited to small areas, the glycerole of the subacetate of lead and glycerine, of each one ounce added to a pint of water, often acts admirably. When itching is present resorcin or carbolic acid are the best agents we possess for allaying it. These are used in the form of lotions, one drachm to four ounces of water. Sometimes cloths saturated with a bland oil prove most grateful to the patient. During convalescence, especially in the exfoliative form, some emollient, such as vaseline or the benzoated zinc ointment, is to be recommended.

Dr. George Dock writes of

**Pernicious Malarial Fever,**

reporting a fatal case. The parasites encountered in this case seem to be identical with those described by Marchiafava and Celli as the small plasmodium, or the parasite of summer and autumn in Rome. They agree, so far as one can determine by descriptions and without actual comparisons, in the size of the fully developed organism, their short cycle (about twenty-four hours), their lively motion, and the peculiarities of the spore figure and of the pigment. The growth of the parasites was checked almost completely very soon after the patient's death. The author cannot say whether this was due to lack of oxygen or to altered temperature, or to other causes.

The paper is illustrated with half-tone cuts of the microscopical appearances of the blood and splenic juice.

John Croft, F.R.C.S., England, contributes a paper on

**The Mortality after Operations for Strangulated Hernia; the Treatment of Gangrenous Intestine, and the Radical Cure of Hernia.**

In his own experience the mortality of the operation has been reduced from 50 per cent. in pre-antiseptic times to 29½ per cent. at present. The author discusses the questions of artificial anus, and primary resection and suture, deciding that no hard and fast rule can govern these cases, but each must be decided on its own merits. In regard to removing the omentum in cases of strangulated hernia, the author believes it wiser to cut off the omentum antiseptically than to run the risk of bruising it and even tearing it by pushing it back through a relatively narrow orifice. When in doubt, remove it antiseptically is a good rule.

In answer to the question as to whether a radical cure should be attempted in operations for radical hernia, he says that all patients suffering from strangulated hernia should be given the advantage of a radical cure; and he goes farther and says that all patients suffering from obstructed hernia should be advised to submit to early operation and radical cure. He attaches great importance to placing the ligature high up on the neck of the sac. In many cases of inguinal hernia he fastened one end of the sac-ligatures to the internal oblique and inner pillar of the ring, but he doubts the value of it. In almost all instances of inguinal hernia he brought together the pillars of the ring by sutures, at the same time avoiding any pressure on the constituents of the spermatic cord. For sutures he gives the preference to silk as more durable and reliable.

The remaining papers in this issue are: "A Case of Non-hereditary Friedreich's Disease," by Hector W. G. Mackenzie, M.A., M.D.

"A Case of Tuberculosis of the Skin Simulating Lupus Erythematosus and Erythematoid Lupus Vulgaris," by W. A. Hardaway, M.D.

"A Case of Locomotor Ataxia Beginning in the Arms," by J. K. Mitchell, M.D.

"A Case of Fracture and Dislocation of the Second Lumbar Vertebra, with Operation," by Richard C. Newton, M.D. The patient died five and one-half days after operation. Dr. Henry Power presents a report of the microscopical examination of the spinal cord.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## THERAPEUTICS.

### A New Anti-Neuralgic and Anti-Rheumatic.

In an article in the *Deut. Med. Woch.*, No. 18, 1893, Dr. Edmund Koch writes as follows: "All reports speak in satisfactory terms regarding the prompt action obtained with Salophen in acute articular rheumatism. In doses of three to five grains or at most six grains per day it rapidly diminished the fever pains and swelling; and in laudatory terms it is pointed out that in this affection it has the same action as Salicylate of Soda and Salol, but it is preferable to them on account of its agreeable taste and the absence of disagreeable after effects. In older cases, as well as those which have become chronic and have persisted for many years, and in the arthritis deformans it is frequently ineffective, but may be alternated with advantage with other remedies the more so since it sometimes relieves the pains at least the beginning. The dose here varies from 4 to 6 grms per day. The chief domain of Salophen, however, is the large field of nervous diseases of every kind; neuralgias, such as sciatica, pleurodynia, intercostal neuralgia, neuritis, hemicrania, and odontalgias as well as other painful affections. In mild cases, a dose of 0.75 grms is effective; in the more severe, larger doses up to 3 or 4 grms must of course be employed. Only a few cases of nervous diseases fail to yield to this treatment.

The remedy is best administered in the form of powder in doses of 0.75 grms. Owing to its tastelessness it is readily taken in doses of 3 to 5 grms, which are amply sufficient. It is devoid of any after effects.

### Pental.

Phillip (*Zeitshrift f. Kinderheilk.*, Bd. iii., 4 1893) states that during the preceding twelve months chloroform and pental were the only anæsthetics used in the Kaiser Fredrich Chil-

dren's hospital, Berlin, local anodynes having been found impracticable in the case of children. The following were found to be the principal advantages of pental: Extraordinarily rapid narcosis; rarity of a period of excitement, which, if present, ceased with absolute narcosis; immediate recovery of consciousness after removal of the mass; and absence of any unpleasant after-effects such as are caused by chloroform. No action on the heart was ever observed, but in some patients arrest of respiration and cyanosis occasionally appeared, when removal of the mask sufficed to restore the natural color. The author attributes the cyanosis, not to any toxic action on the respiratory centre, but to tonic contraction of the diaphram and glottis. In twenty-one cases the urine was subsequently examined for albumin, but not only was a trace found, which disappeared on the third day; this occurred in a tuberculous child after a prolonged operation. The majority of the operations lasted from ten to thirty minutes, from thirty to sixty cubic centimetres of pental being required. In conclusion, judging by one thousand narcoses, pental is, with certain exceptions, always able to replace chloroform, being, moreover, less dangerous and without after effects. In the above-named hospital pental is now looked upon as an indispensable drug, but during its use all precautions should be taken as when administering chloroform.—*British Medical Journal*, February 17, 1894.

## MEDICINE

### Etiology of Bronchitis.

Marfan and Claisse (*Boston Medical and Surgical Journal*) place bronchitis among the germ diseases. They claim that by the sudden chilling of the cutaneous surface, and especially when the body has been overheated and is perspiring, the blood is chilled and carried to the internal organs, causing such changes that the microbes which commonly infest the upper air passages and bronchi find a favorable condition for their multiplication and pathological operations. Under ordinary conditions the leucocytes are able to control the invading hosts, but the congestion (plus something else as yet not understood) produced by the sudden chilling of the surface places the organism in a state of lessened resistance, and the enemy enters and possesses the country for a period varying from two to five weeks.—*Amer. Pract. and News.*

### Ergot in The Treatment of Periodical Neuralgias.

Dr. William H. Thompson read a paper on this subject, in which he gave the histories of a number of cases of severe periodical neuralgias in which the symptoms had been promptly relieved by the use of ergot in large doses. In all of these cases the disease had been of long standing, and the usual remedies had been employed without avail. Dr. Thompson said his method of administering the ergot in migraine was as follows: The fluid extract of the drug was employed, combined with an equal quanity of elixir of cinchona, to obviate the tendency to cause nausea. Two drachms of this mixture were to be taken in water as soon as the premonitory symptoms of the headache were noticed, and the patient was advised to lie down and keep very quiet. If, after an hour, the headache continued, a second similar dose was taken, and then a third in another hour if necessary. As nausea was such a general accompaniment of this affection, it was provided that if either of the doses be vomited it should then be taken in an enema of two ounces of water. This medication, the speaker said, rarely failed to arrest the attacks, even in long-standing cases, and with a preventive course of intestinal antisepsis in the intervals.—*N. Y. Med. Jour.*

### The Therapeutics of Oxygen.

Dr. A. W. Catlin, of Brooklyn, read a paper in which he stated that the therapeutic use of oxygen was of very recent date. The treatment of disease by natural means was proving more and more efficacious as experience increased. Oxygen was a distinct remedial agent—one that should not be left untried until the patient was *in extremis*. It was the surest and most satisfactory stimulant that we possessed, and was applicable to many conditions. In profound shock, from whatever cause, it had been found to exercise a reviving effect. It was taken up quickly by the blood, but its chief value was in its effect upon the nerve centers, upon which it exercised a quieting and soothing effect. In hemorrhage from typhoid fever he had seen relief in many cases. It would produce sleep, favor assimilation, and shorten the period of convalescence of typhoid fever. No agent was so well tolerated or so useful in restoring the equipoise of the physical condition. In cases of childbirth, pneumonia, bronchitis, and other exhausting diseases, the use of oxygen was indicated, and it should not be given late but early.—*N. Y. Med. Jour.*

### The Treatment of Pregnancy Complicated by Heart Disease.

Dr. Geo. G. Sears in a paper upon this subject summarizes his conclusions as follows:

1. That many women with valvular disease, even when situated at the mitral orifice, pass through repeated pregnancies without the development of serious symptoms, and at times without suspecting that they are victims of such disease.

2. That as miscarriages are very frequent, and the chances of the child's surviving more than a few years are doubtful, if the mother's condition during pregnancy has been serious, the probable fate of the latter should take so much more prominence in deciding the question of abortion.

3. That the necessity of inducing abortion is very probable if grave symptoms have appeared during the early months, or are present with an advancing lesion, or if there is a

history of extreme danger in the preceding pregnancy.

4. That if the necessity for an abortion becomes apparent, the sooner it is done the better, while the fetus is still small and the expulsive force chiefly furnished by the uterus.

5. That the hope that relief may be given when the case has become desperate by inducing abortion is delusive, as it is possible that it only increases the danger.

6. That marriage should be forbidden except, perhaps, in very unusual cases, to women suffering from cardiac disease—*Boston Med. and Surg. Jour.*

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### On the use of Antiseptics in the Treatment of Typhoid Fever.

Dr. E. N. Nason, in a paper read before the Birmingham branch of the British Medical Association under the above caption states that the ideal antiseptic in typhoid fever which has yet to be discovered must fulfil the following conditions.

1. It must be innocuous to the patient.

2. It must be destructive of micro-organismal action, without interfering with the normal digestive ferments.

3. It must reach the small intestine while

4. It must be capable of absorption from the intestines, and not a completely insoluble substance.

still operative.

He employes as an antiseptic a preparation which he calls chlorinated quinine, and which is prepared in the following way as suggested by Dr. Burney Yeo:

Into a 12-oz. bottle place about 30 grs. of chlorate of potassum, and upon this pour 40 grains of strong hydrochloric acid. A yellowish-green gas is given off, which should be allowed to accummulate in the bottle, then add water, an ounce or so at a time, shaking well as the water is added. The gas dissolves in water forming a yellowish-green solution and smelling strongly of chlorine. This solution contains free chlorine, peroxide of chlorine, protoxile of chlorine, and some unde-composed chlorate of potassium. To this is added 24 grs. of quinine, and a little syrup of orange. The mixture should be kept in a cool, dark place as it decomposes under the influence of a bright light. An ounce of this should be given every 3 or 4 hours to an adult, for children a proportionately small dose. While not contending that this particular mixture is necessarily the best the form of antiseptic to be used, he recommends it, and claims the following advantages over the expectant method from its use.

First those which may be constantly expected:

1. Reduction of temperature to a greater or less extent.

2. Improvement in condition of tongue and mouth.

3. Reduction of fetor of stools.

4. Improvement in general appearance and condition, with a greater sense of well being, and less hebetude.

5. Prevention of excessive fermentation or putrefactive changes in intestine with consequent tympanites.

Second those occuring with greater frequency than ordinarily:

1. Abortive attacks.
2. Freedom from complications.
3. Shortened febrile period.
4. More rapid convalescence.
5. Low mortality.

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## ARMY AND NAVY.

### U. S. ARMY FROM APRIL 1, 1894, TO APRIL 7, 1894.

Captain Edward C. Carter, Assistant Surgeon, will proceed at once to Fort Spokane, Washington, and report to the commanding officer for temporary duty.

Leave of absence for twenty-one (21) days, to take effect on or about April 14, 1894, is granted Major Charles L. Heizmann, Surgeon U. S. Army.

The following named officers are detailed to represent the Medical Department of the Army as delegates to the Association of Military Surgeons of the United States, to meet in Washington, May 1, 1894: Lieut. Col. William H. Forwood, Deputy Surgeon General; Major Robert M. O'Reilly, Surgeon; Major Joseph K. Corson, Surgeon; Major Walter Reed, Surgeon; Captain John L. Phillips, Assistant Surgeon; Captain G. L. Edie, Assistant Surgeon.

First Lieut. Henry D. Snyder, Assistant Surgeon, is relieved from duty at Fort Reno, Oklahoma Territory, and ordered to Fort Du Chesne, Utah, for duty at post, relieving Captain Samuel Q. Robinson, Assistant Surgeon.

Captain Robinson, on being relieved by Lieutenant Snyder, will report in person to the commanding Officer, David's Island, New York, for duty at that post.

Major Peter J. A. Cleary, Surgeon, will be relieved from duty at Fort McPherson, Georgia, by the commanding officer of that post, on the receipt by him of this order, and will report in person to the commanding officer, Fort Custer, Montana, for duty at that post.

First Lieut. Edward L. Munson, Assistant Surgeon, will proceed without delay to Camp Merritt, Montana, and report to the commanding officer, for temporary duty at that post.

First Lieut. Charles F. Kieffer, Assistant Surgeon, having reported at Headquarters Dept. Dakota, is assigned to temporary duty at St. Paul, Minn., and will report to the Medical Director of the Department for instructions.

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## ORIGINAL ARTICLES.

### THE ORIGIN AND CAUSES OF PYREXIA IN TYPHOID FEVER.

J. WELLINGTON BYERS, M. D., Charlotte, N. C.

The factor of high temperature with its concomitants of tissue waste, perverted metabolism, and cell inertia, is very generally conceded to furnish the leading indications for treatment in typhoid fever. Indeed antipyresis in some form or other is now regarded as absolutely essential to a rational and successful management of this disorder.

This is substantiated by the fact that a large proportion of modern methods employed recognize and seek to modify and combat this particular symptom. And it may be added, that experience shows that they are all severally successful *pari passu* with their capacity to control harmlessly this most formidable feature. Such being true it is highly proper that we should possess a real and definite knowledge of the origin and causes of the pyrexia in typhoid, in order that they may be attacked and met in an intelligent manner. To accomplish this, it will be necessary to transform some of the current teachings concerning the pathologic conditions ordinarily associated with this disease, and to break away from some misconceptions in regard to what has hitherto been accepted as part of its true clinical history.

With this end in view, we may separate the lesions into two groups, namely, the essential, and the accessory or accidental, lesions. In the first division, we place changes arising from the local action of the bacilli and their concentrated toxines upon the glands and lymphatic structures of the abdomen, together with the more remote effects of the same upon the body, temperature and general nutrition. These effects are the direct result of the bacilli and their products, and constitute the only specific or essential lesions in typhoid fever. In the second group, we have the accessory or accidental lesions, some of which are sometimes present, sometimes absent, sometimes this one and sometimes that one, depending upon the treatment pursued, the patient, the stage of the disease, and other contingencies. Prominent among the lesions of this latter class stands gastro intestinal catarrh and its associated phenomena of perverted digestive and assimilative functions, leading in turn to putrefactive and fermentative changes, and as a final result the absorption of various toxic substances into the general circulation, causing disturbances of temperature, cell destruction, innervation and symptoms of profound constitutional character. As is obvious these latter changes do not emanate from the specific lesions already enumerated, but are accessory and independent factors in the complex result produced in the organism.

The same fact applies to another class of lesions which have long been held to be a part of the true pathology of this disease. I allude to the ulceration that follows in the second and third week and causes such serious symptoms. These glands ulcerate and break down, causing hemorrhage and septic fever, not as a result of the effect of the specific bacilli *per se*, but from the fact that their vitality is lowered by the presence of the latter and the pus-producing cocci are enabled to engraft themselves

upon a tissue which, before, would have resisted them successfully. These lesions of the second class are in no way peculiar to typhoid fever, nor do they constitute essential factors in its true clinical phenomena, but, to the contrary, they are associated with a number of acute febrile infectious diseases, which lower resistance and invite the encroachment of new factors in the form of accidental lesions. The only constant and essential lesion of typhoid fever is the infiltrated non-suppurative inflammation of the solitary and agminated glands of the intestines, associated with a febrile reaction of 100° F., and slight disturbances of the general nutrition of the organism. Everything else, in the light of what has been written, may be regarded as non-specific in character, not peculiar to typhoid fever, but associated phenomena referable to other causes.

Interpreted from this standpoint the question of treatment resolves itself into that of ascertaining exactly what importance, and how much value is to be attached to each of these several factors as co-operants in the complex result of excessive heat. In the present state of our knowledge it is impossible to say absolutely, how much is attributable to each. Judging, however, from the marked and rapid reduction of temperature that usually follows the exhibition of substances capable of evacuating the contents of the bowel and arresting putrefactive changes transpiring therein, we are warranted in concluding that the larger proportion of the pyrexia is directly due to these causes and not as is generally supposed, to the product of the specific lesions or the bacilli and the pathologic changes in the glands. In an experience with sixty cases of typhoid fever I have put to test the principles here announced and I have demonstrated that they are true beyond peradventure of a doubt.

Starting with the idea that the pyrexia is the product of a mixed infection, complex in character and largely the result of fermentation and putrefaction in the intestinal canal, I have used agents qualified to arrest decomposition and keep the bowel comparatively empty. By doing this the temperature has been kept exceedingly low and dangerous symptoms entirely avoided. My plan has been to administer from the beginning of the attack, the sixth of a grain of calomel combined with sugar and soda, every hour until the bowel has been freely evacuated. This is repeated every day or every other day during the entire illness unless contra-indications supervene, such as excessive purging, prostration and nausea—which I may add are very rare—when the drug is stopped for a while. When calomel is used in this way, my experience shows that the functions of the gastro-intestinal tract are speedily resumed and kept in a physiological condition, the tongue cleans off and becomes moist, tympany is absent, the fever declines at once and remains low, scarcely ever beyond 102° F., and the patient presents an array of symptoms which every way indicate that he is better. By pursuing this method the fever rarely exceeded 102° F., and when it did, it was invariably found to be the result of retained and decomposed food substances, and speedily declined upon their removal by the medicine. When calomel is used in this way there is little or no danger from hyper-catharsis or salivation, nor does it induce asthenic conditions. To the contrary, it is a general cell stimulant, promotes glandular action and opens up the emunctories in the best possible manner, and in this way eliminates the morbid substances from the internal tissues as well as from the canal.

As a remedy for the routine treatment of typhoid fever, supplemented by such other agencies as the individuality of each case may demand when the accessory lesions predominate, calomel will demonstrate its utility beyond question. That it will prevent or lessen a considerable part of the pyrexia that usually accompanies this disease, unless treated by direct antipyretics which do not reach the real seat and cause of the former, I am quite certain. By the use of the calomel we not only avoid the high temperature, conserve the vital resistance of the organism and bring about a speedy convalescence, but the appetite and digestion remain good, the stupor and delirium of toxæmia are altogether absent, and the ulceration, hemorrhage and perforation so much dreaded in this disease do not occur and the most potent causes of mortality are removed.

In a recent paper by W. B. Thistle, of Toronto, Canada (*N. Y. Med. Record*, Vol. 45, No. 10), is given the results of this eliminative and antiseptic treatment

in forty consecutive cases of typhoid fever. There were no deaths or unfavorable symptoms in any case. Average attainment of normal temperature on the twelfth day and entrance on convalescence. No hemorrhage. No perforation. Tympanites was present in only one case, but quickly disappeared. In fifteen of his cases the characteristic rash occurred showing the diagnosis to be correct.

For a safe, ancient and successful remedy, controlling and preventing as it does the most serious symptoms in this disease, I can commend calomel in the manner set forth above, as the most efficient of remedies in typhoid fever.

## A CASE OF TYPHOID FEVER, WITH SEVERAL RELAPSES.

MARY H. THOMPSON, M. D.,* CHICAGO.

This case of typhoid fever was to me exceptional, because of its four periods of fever within eight weeks, and its many complications, some co-existing at the same time, and others arising at several different times.

The case was attended at its beginning (during my absence from the city), by Dr. Annette Richard, who invited me to take charge of it when I returned, as it was in a family where I had had the medical care for several years.

July 30, Dr. Richards was called to Mrs. P., who was forty-nine years of age, and had been a very healthy woman up to about five months previous to her present illness, when she had the then prevailing epidemic, influenza, and a diarrhœa which threatened to become chronic, and from the effects of which she had hardly recovered, although she had called herself well during the previous summer.

Dr. Richards found her with a general *malaise* and an intense headache, backache, pain in the left side and abdomen. The doctor learned that she had been ill a week, with all the present symptoms. The patient, at this time, had an afternoon temperature of 103° F., and was at the same time so chilly as to require artificial heat applied to the extremities during the height of the temperature. The morning's highest temperature was a degree less than that of the afternoon. She had nausea; the renal secretion was dark and thick, though of normal quantity.

The fever followed about the usual typhoid type, until it had run about two weeks from its commencement. The highest afternoon temperature of this period was 103.5° F. There were no other peculiar symptoms, during this period, than that the height of chill was not fully developed, until the thermometer and patient's face indicated that the highest thermal point had been reached for the day.

August 10. The patient was considered convalescent; temperature and pulse remaining normal two days, then suddenly rising with the on-coming chills.

On the 12th, the temperature rose to 103°F.; the next day it was slightly less, and on the 14th was normal. Again on the 17th it came up suddenly to 104°F., with chills, nausea, and the other symptoms mentioned, and on the 19th it was again normal, and remained so until the 26th. On the 20th a large amount of sloughs passed with the stool twice, and on the 22nd they passed with "greenish yellow matter," as reported on the nurse's record; also on the 24th, 26th and 28th.

On the 26th the fever arose to 103.2°F., and continued rising daily until it reached 105.5°F., and stood nearly as high the succeeding eight days, marking the time for defervescence by dropping to 103° F. for an hour only, morning and evening, the pulse ranging from 90 to 120 in its beats.

On September 4th I was requested to take charge of the case, which I did after consultation with Dr. Richards and Dr. John Bartlett.

I found her with a pulse of 104 and 120, and dicrotic; the temperature was from 103 to 105° F. There was peritonitis, great tenderness and some meteorism of abdomen; tremor, and nausea from catarrh of the head, pharyngitis and laryngitis; there was bronchitis, pain in the renal region, congestion of the pelvis, and ex-

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coriation of the urethra occurred, from which she suffered much.

The renal secretion, though dark, was of normal quantity and above; but this was scarcely noticed until after convalescence, when the record was again referred to. The bladder was washed with warm water and urethra treated. The spleen was so tender that she could scarcely bear the light pressure of bed-clothes, and when turned slightly upon the left side, she was glad to be immediately turned back, to relieve the pain in that side.

September 7th. Meteorism was so great, and gas accumulating so rapidly, that I ordered a syringe rectal tube inserted a short time, twice in the day, by which to remove the gas, as after laparotomy; the intestines were becoming so paralyzed that I looked for perforation, and thought it better to allow increased peristalsis, from the insertion of the tube, than that perforation should occur from such great distension. The mucous from the head and throat provoked vomiting, and milk, though containing one-fourth of its bulk of lime water, was instantly expelled in hard coagula. Constipation continued throughout the fever and was counteracted by enemas.

September 8th. The pulse was distinctly dicrotic; the tremor so great that the patient seemed about to lose form and fall apart, jelly-like. After my visit of the morning I was recalled at noon, as the patient was having "hemorrhage of the bowels," as the messenger reported. I found that a "pint of red blood had passed," as the nurse stated. Turpentine stupes, that the patient had worn under the poultices, were then changed for large compresses, steeped in vinegar and placed over the whole abdomen, and the vinegar of opium was the only medicine given by mouth as the stomach was so irritable, and this in minute quantities.

On the next day there were four stools of clear dark blood and clots only; on the third day there was one large stool of the same dark blood, without clot. About eight days after the hemorrhage began she had a rise in temperature from a sub-normal one to 101° F., followed by an unusually offensive stool, containing much dark greenish blood, after which the temperature fell to normal again. Evidently this was all one hemorrhage, as indicated by the different degrees of decomposed blood, and was estimated to be not less than four pounds.

Subsequent to the first hemorrhage came the most profuse perspiration that I ever witnessed. In twelve hours after it began, the patient had the appearance of having been parboiled, and was dried and changed, as after a bath, several times in twenty-four hours. She also complained that she could hardly see. The failure of eyesight continued for several days. The temperature became sub-normal (the nurse said 94° F.) I took it when it scarcely reached 95°. The pulse was very weak, and but sixty beats per minute. The patient was really cold to the touch, as if all bodily heat had left her.

Numerous bottles of hot water were placed around her, and placed in her hands, thus adding warmth to keep up the circulation. It was difficult to keep up the heart's action, because of the rapidity with which the blood lost its serum, which, with the hemorrhage and perspiration combined must have equalled that in Asiatic cholera.

After the discharge of the last decomposed blood, slow but sure convalescence began. After I had ceased my daily visits, while calling one day, the patient complained that she had no rest day or night, because of frequent micturition, and that the renal secretion was so great. The next day I saw it measured for the twenty-four hours, and it was six quarts; it was dark and heavy with urates, but contained no albumin or sugar. I then referred to the nurse's record again, and saw that, from the commencement of the fever, the quantity had been variable, from twenty-five to forty-two ounces per day; the larger quantities later in the fever, and increasing in amount with convalescence. With a warmer atmosphere, and a dress of flannel, and a liberal use of the tincture ferri chloridi, well diluted, that it might not irritate the diseased mucous membranes, this diuresis was much lessened; after which she became affected with articular rheumatism "in all the joints of the body."

The last disease nearly disappeared in a month or so, and she now, seven months since her fever, is looking more natural and has gained flesh, though the renal secretion is yet more than normal, and she is occasionally slightly lame from the rheumatism.

I am forced to conclude that the rheumatism was the result of checking the elimination of the urates; but I cannot come to a conclusion in regard to the cause of the diuresis with so much uric acid during a typhoid fever.

In reviewing the case, I ask myself, as wiser physicians have done from time immemorial: "What is fever? What its cause and what its result on blood and tissue?" There was increased tissue change here, from bone to brain. There were four periods of fever; *one* of *two weeks*, followed by an interval of two days. The *second* and *third* were of two days each, with an interval between of two days, succeeded by an interval of eight days, and a fourth period of thirteen days, which was nearly one continuous paroxysm, her temperature falling to 103° F., but for about an hour at a time, twice daily.

The second and third short periods were of sudden rise of temperature and slow defervescence. The last, the fourth, beginning on the 26th, six days after the sloughs appeared, I attributed to the sloughing process; but then the question arose as to *why* it did not occur before!

Just previous to the hemorrhage, there was shallow breathing, great tremor, a dicrotic pulse, and such increasing peritonitis that I expected perforation. While thinking how it could be met (for I had never had it occur in my practice, and this was the first time I had anticipated it) I then realized how useless it would be to make a long enough abdominal incision to handle the probable length of intestine affected, to find one diminutive perforation hidden away in near proximity to the mesentery in a most difficult locality to discover.

The manipulation of the diseased bowel, possibly from the cæcum to the pyloric orifice of the stomach, might cause more perforations and the operator leave those thus made, from which the patient would succumb after the closure of the wound; for I have made examinations when there were several patches ulcerated to the peritoneal coverings.

After such a long burning fever, can we expect the blood to be plastic enough to allow new wounds to unite? In this case the hemorrage was succeeded by the defervescence with the very profuse perspiration.

The fever was presumably the effect of drinking unsterilized lake water; and there were two causes for its severity. One, the effect of the previous illness, and the other that her room had no direct rays of sunlight in it, as it was a north room, between two extensions, which subjected it to much shade and in this room she had slept since the May previous.

The influence of sunlight cannot be too highly prized during the treatment and convalescence of typhoid patients. It is reported that Buchner has come to the conclusion, after well-tried experiments, that the effect of the direct rays of sunlight upon bacteria, suspended in water, is to deprive them of vitality; among the variety experimented upon by him was the typhoid bacillus. He suggests that it is this power of the self-purification of running streams that purifies, instead of the action of the water.

If it be proved that Buchner's conclusions are correct, we can expose our patients to the sun's rays and get the same effect, modifying the disease, as there seems to be no remedy by which this so-called "self-limited disease" can in any way be cut short before it, in many instances, destroys the patient's life.

If bacteria are destroyed while in water, why may they not be in the capillaries of the surface of the human body, which though less transparent than a stream of water, is exposed in many square feet of surface in the cuticle, and carries so much blood, the cuticle being the largest organ in the body?

For many years the hygienic treatment of typhoid fever has been to place the patients in well-ventilated rooms, and I would say, in well-sunned rooms. If, during convalescence, a patient is able to be out of his or her room a portion of the day, open it to the sun's direct rays, however hot, during the absence, and always when the patient returns, if practicable.

Do all the present theories of typhoid fever coincide with what we know to be facts? Instance, the pulse is quickned by the influence of the fever, in some way, until the beats are doubled in their number for a given time. Does the theory that the blood is filled with the typhoid bacilli, harmonize with the fact that a foreign body, when introduced into the blood, even while circulating in the blood vessels, affects the formation of fibrin at the locality in which the circulation has been in-

terrupted? Instead of obstructing circulation, do not these bacilli quicken it? If these microscopical bodies have life, and are capable of movement, and are even so small as to pass the lumen of the minutest capillaries, or the walls of the same vessels, one effect should be to thicken this fluid, hence retard the circulation instead of hastening it.

What other influences are at work in this physiological process? The muscular force is weakening, so also the nervous. How are such bacteria eliminated from the system? When we say this fever was the effect of drinking unsterilized lake water, is it saying that the typhoid bacilli are in the water? Some authors assert that sewage alone will not cause this fever. If typhoid bacilli are now in the lake water, are we, in Chicago, to have a perpetual typhoid, or can we turn to Buchner's conclusion, and feel assured that the vitality of those bacteria, now in the water, will eventually be destroyed, and with no new increase, when sewage containing them is turned away?

I have referred but little to treatment, other than exposing the patient to the sunlight, as there is so little to do but direct the care in nursing, which includes feeding, and keeping a patient quiet, both mentally and physically. Yet with every new case I find myself prescribing some one or more of the following remedies: The solution of chlorate of potash, carbolic acid, aromatic sulphuric acid, quinia sulphate, and I have used, in several cases, after the first of the second week, light poultices of simple flaxseed meal over the abdomen, hoping to modify the swelling of Peyer's glands and preserve them from ulcerating.

I have given the chlorate of potash in the beginning of the disease, and carbolic acid later.

## COMMUNICATIONS.

### THE ADULTERATION OF FOOD.*

H. W. WILEY.†

Barnum made a colossal fortune by acting on the principle that Americans like to be humbugged. To be cheated, fooled, bamboozled, cajoled, deceived, pettifogged, demagogued, hypnotized, manicured and chiropodized are privileges dear to us all. Woe be to that paternalism in government which shall attempt to deprive us of these inalienable rights. There is no point on which the average American is more sensitive in respect of legal restriction, than in those instances in which the law interposes to prevent him from making a fool of himself.

In regard to the character of what we eat and drink, we find the same unwillingness to be watched over and protected.

A few days ago in Chicago I went out to the Union Stock Yards to look at the process of meat inspection. From each carcass of pork intended for exportation is taken a sample of the flesh, and this is carefully examined for trichinæ. "Do you often find diseased samples?" I asked. "Yes," said the attendant, "from one to two per cent. of all the samples examined is found infected." "Could I see a sample of that kind?" "Certainly. Has anyone a trichinosed sample in the microscope?" A pretty girl microscopist held up her hand. I looked and saw for myself the curled and coiled serpent ready for a strike. How I congratulated that lucky sarcophagous Teuton who had been saved from a horrid death by the fairy fingers and sure blue eyes of the trichinæ girl. "What do they do with these infected carcasses?" A shrug of the shoulders led me to believe that they were sent to soap factories, as they doubtless are, and this was followed by the expression: "But Americans don't eat raw pork," and I am led to suppose from this that trichinæ are really very good and nice when well broiled. Next morning, when I ordered ham for breakfast, I asked the waiter to have it cut thin and broiled crisp. Even then when

* A lecture delivered before the Franklin Institute, and reported in the journal of that institution. Condensed.

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it was brought in I could not help thinking that it looked like a bretzel.

That distinguished jurisconsult and patriot, Senator Paddock, of Nebraska, during the first session of the present Congress, after years of futile struggle, succeeded in having the Senate pass what is known as the Pure Food Bill, but it seems from the provisions of this bill that the Congress of the United States has only power to protect the foreigner, the disfranchised and the Indian not taxed. The provisions of the bill are confined to the Territories and the District of Columbia and to interstate commerce. Mild as are the penalties of the bill, allowing the citizens of any State to make a dessert and call it peas if they like, yet it has been left unpassed in the House of Representatives.

The Paddock Pure Food Bill, to summarize it briefly, has for its purpose the protection of commerce in food products and drugs between the several States, the District of Columbia, the Territories of the United States and foreign countries, and the Secretary of Agriculture is authorized to make the necessary rules for carrying out the objects of the bill. He is authorized to cause to be punished, through the proper courts, any one introducing in any State or Territory, or the District of Columbia, or from any foreign country any article of food or drugs which is adulterated or misbranded. The act says that the term "food" shall include all articles used for food or drink by man, whether simple, mixed or compound. In the case of food or drink, an article shall be deemed to be adulterated if any substance or substances has or have been mixed and packed with it so as to reduce or lower or injuriously affect its quality or strength, so that such product when offered for sale shall be calculated to deceive the purchaser; further, if it contain any inferior substance or substances substituted wholly or in part for the article, or if any valuable constituent of the article have been wholly or in part abstracted, or, if it be an imitation of, and sold under the specific name of, another article, or if it be mixed, colored, powdered or stained in a manner whereby any imperfection therein shall be concealed, or if it contain any added poisonous ingredient or any ingredient which may render such article injurious to the health of the person consuming it. Further, the food is declared to be adulterated if it consist of the whole or any part of a diseased, filthy, decomposed or putrid animal or vegetable substance or any portion of an animal unfit for food, provided that an article of food shall not be considered adulterated if it be a mixture or compound sold under its own distinctive name, or an article labelled, branded or tagged so as to plainly indicate that it is a mixture, compound, combination or blend.

It will be seen by the above provisions that the bill is very far-reaching in its character, and it contains also the proper penalty for enforcing its operation. This bill passed the United States Senate on March 9, 1892.

This Pure Food Bill has received the unanimous support of nearly every agricultural organization in the United States. It has been opposed by a number of manufacturing establishments interested in the production of drugs and mixed foods, and also by those largely interested in the manufacture of substitutes for lard. If adopted it can at once be seen that it would do away with the necessity of the oleomargarine law, which is a special form of legislation, and like all special legislation, must be open to many objections.

As before stated, the national law, as indicated above, does not protect the citizen of any State against an adulterated food which is manufactured and sold within the State. Such police power must be left wholly to the several States. Many of the States already have laws on their statute books dealing with the subject of food adulteration. These laws, however, are for the most part, inoperative, and, not being based on a common plan, would naturally not secure, even when fully enforced, the same degree of protection in all States. What is needed for a complete legal protection of the people against adulterated foods is not only the enactment of the Paddock Pure Food Bill, but a similar enactment of similar scope and aim for each of the several States.

Among the various States which have laws on the subject may be mentioned Illinois, which has an act to prevent and punish the adulteration of articles of food, drink, and medicine, and the sale thereof when adulterated. There is also a special law preventing the adulteration of butter and cheese.

Iowa has a statute, entitled "an act to prevent deception in the manufacture and sale of imitation butter and cheese." One of the provisions of this law is that no keeper of a hotel, boarding-house, restaurant or other public place of entertainment shall knowingly place before any patron, for use as food, any imitation butter or imitation cheese unless the same be accompanied by a placard containing the name in English of such article printed in plain Roman type. Iowa also has a special law in regard to the adulteration of milk.

Maine has a food law to prevent the manufacture and sale of adulterated lard. Maine also has a general law on the adulteration of food and drinks.

Maryland has a statute to provide for the prevention of the adulteration of articles of food and drink and the sale thereof when adulterated or unwholesome. The enforcement of this law is placed largely in the hands of the State Board of Health.

Perhaps the best of the State laws concerning adulteration, are those of Massachusetts, the statutes of which provide "that no person shall within this Commonwealth, manufacture for sale, offer for sale, or sell, any drug or article of food which is adulterated within the meaning of this law." The law of Massachusetts is, in all essential particulars, that of the Paddock Pure Food Bill, of course, with such variations as are necessary in the enactment of a State law as compared with a Federal law. The law of Massachusetts is especially effective as regards the sale of adulterated milk and other adulterated food, and has a system of State inspection which has already reduced the percentage of adulteration of such articles to a very low figure. Monthly returns are made by the inspectors and analysts of foods and drugs. The report for the month of October, which is the latest one, contains the results of the inspection of milk, butter, cheese, olive oil, vinegar, spices, cream of tartar, molasses, maple sugar, maple syrup, honey, tea, coffee, confectionery and miscellaneous articles and drugs. The total number of samples examined was 610; the number found to conform to the legal standard was 428, and the number of samples varying from the legal standard—that is, adulterated within the meaning of the act, 182. The percentage of the adulteration was 29.8. The actual percentage of adulteration is very much less than this, for it is only suspicious articles of food to which the attention of the Board is directed. Certain staple products, such as sugar, flour, and the various cereal products, are very rarely adulterated and receive but little inspection.

The case of Massachusetts is given somewhat at length on account of the excellence of the system of inspection. It shows what a State law can accomplish when wisely made and honestly enforced. In the one item of milk alone, it would be difficult to estimate the amount which has been saved to consumers by the strict enforcement of the law which requires the milk sold to contain a certain amount of total solids and fat.

Time remains only to mention the other States which have laws of some kind on the subject of adulteration. These States are Michigan, Minnesota (which has a series of good laws, both special and general), New Hampshire, New Jersey (which also has a good system of laws), New York, Ohio (also with a fairly good system), and Pennsylvania, which divides its law into three sections; the first relating to liquors, I suppose because this is the most important of the foods of this State; the second to food adulteration in general, and the third especially to dairy products. The weakness of the Pennsylvania law is not so much in the character of the provisions relating to the sale of foods as in the method of securing their enforcement. It does not provide for any system of inspection as does the law of Massachusetts; and no law relating to the adulteration of food is of any value whatever as a protection to the community unless a rigid system of constant inspection is provided for. The Pennsylvania law declares that the addition of water or of ice to milk is an adulteration, and any milk obtained from animals fed on distillery waste is declared to be impure and unwholesome. The removal of the cream is also declared an adulteration. The law prevents the manufacture of any substance provided to take the place of pure butter fat. This is not a restriction on the sale of an adulterated butter, but is a total prohibition of the manufacture and sale of any substitute for butter, even if it be sold under its own proper name.

Continuing the list of States with laws against the adulteration of food, we have

next Virginia and Wisconsin. The latter State has a very good law, which not only has a general provision but also enters into detail, especially in regard to dairy products, describing what shall be considered pure milk, or establishing a standard thereof, and stating how an adulteration of milk shall be proved, and how adulterated honey shall be marked. It contains penalties for the sale of unwholesome provisions and items in regard to the adulteration of foods and drugs, fraud in dairy manufactories, the form of label to be placed on dairy products, the strength of vinegar, etc.

It is hardly patent to this lecture to refer to foreign countries, but it may be said that in general the best laws in this country, national and federal, are based on the English food and drugs act, which is entitled an act to make better provision for the sale of food and drugs in a pure state. This became a law on the 11th of August, 1875.

The laws of the continental countries of Europe are also in the main effective, but contain such a multitude of minutiæ as would render them very burdensome if enacted in this country. The English law has been in operation long enough to prove its efficiency, and under it hundreds of convictions for the sale of impure foods and drugs have been secured.

The Canadian law is essentially the same as that of England, although not so comprehensive.

The States not mentioned in the above list have, so far as could be ascertained, no laws relating to the adulteration of foods. At least they were not reported, although inquiries were sent to the Secretary of State of each State in the Union for information in regard to this matter.

Many municipalities also have local laws applying to the sale of adulterated foods. These laws are mostly of a specific nature and apply chiefly to dairy products. There would be no time here to even mention the cities having local laws on this subject, but there are now very few large cities in the country which do not at least have some kind of milk inspection.

Lying at the root of the question of food adulteration is the inquiry, what is meant by pure food? In the laws which have been enumerated, attempts have been made to legally decide what pure food is. Divested of all legal technicality, pure food is a wholesome article of food or drink which is sold and consumed under its proper name. With each particular article there must be established a separate standard which a consensus of experience with a great number of known pure substances in that list shows to be required. For instance, take the case of milk, which is one of the most common articles of food and perhaps has been more generally adulterated than any other one. Analyses made all over the world on hundreds of thousands of samples of healthy cow's milk, have shown that the average content of solids therein is practically nearly thirteen per cent. A normal milk which falls below this standard shows some peculiarity in the animal giving it, either an incipient disease, deficient nutrition, or some idiosyncrasy. The milk of a herd of healthy animals will rarely fall below this standard. For this reason the standard of twelve and one-half per cent. of total solids in milk has been adopted in most countries having laws on the subject. In some cases the benefit of the doubt is given to the vendor, and a standard is fixed at twelve per cent. Now of these total solids a certain quantity in normal milk must be butter fat. It is not often that the butter fat of a perfectly healthy cow's milk falls below three per cent. of the total weight of the milk. It is much more apt to be three and one-half per cent.; hence, in fixing a standard of pure milk not only must the percentage of solids be given, namely, twelve or twelve and one-half per cent., as the case may be, but also the quantity of fat contained therein. This percentage varies in different laws from two and three-fourths to three and one-half per cent.

In a similar method the standard of purity of any other article of food must be determined by a careful examination of pure samples from all quarters and by then fixing a standard below which an article must be regarded as suspicious or adulterated.

As a distinction between a pure and an adulterated article take the cases of butter and oleomargarine. Pure butter, for instance, must be clean, sweet, wholesome and made of the fat of cow's milk and must contain only a certain proportion of water, curd and salt. Oleomargarine may be as sweet, clean and wholesome as the butter mentioned above, yet

when sold as butter it is clearly not pure food, but a spurious article.

Again, when the housewife buys lard it is supposed that the article she obtains has been made from the fat of healthy, freshly slaughtered hogs, carefully selected and cleaned and rendered in clean kettles or tanks. Cotton-seed oil and beef tallow, in respect of cleanliness, nutritive properties and the wholesomeness may equal and even excel pure lard, but the admixture of these article with hog's lard, or their sale as such without the knowledge of consumers, is clearly a fraud and an adulteration.

From a practical point of view, food adulteration may be considered under two general aspects, namely:

(1) Adulteration harmless to health and practised merely for cheapening the article or making it more attractive to the sight or taste.

(2) The addition to a food or drink of substances positively injurious to health.

Such substances are added chiefly as preservatives or for the purposes of coloring or declorizing, or for the purpose of giving a particular flavor or taste. As a rule, they are added in minute quantities. In fact, the proportion of such substances is usually so small that a moderate or intermittent use of food so treated may not produce any great injury to the system. The continued use of such articles, however, must end in the impairment of the general health and sometimes in permanent injury.

In the latter class of adulterations must also be included those injurious substances naturally arising from the decay of wholesome food, or from the development of noxious substances in canned foods, or from the formation of poisonous salts by the action of the canned foods on the solder and tin of cans. Such materials, while not intentionally added, are, nevertheless, adulterations within the true scope and meaning of the term as applied to foods. In other words, it is not necessary to prove intent in order to establish the fact of adulteration. Any food which is not what it purports to be, which contains any unwholesome or poisonous ingredient, or which has any artificial coloring or facing material, is, to all intents and purposes, adulterated.

There is one legal exception to the above classification, namely, the use of annatto in coloring butter. The national oleomargarine law, applied to the Territories, the District of Columbia and to interstate commerce, permits an artificially colored butter to be passed as genuine, and I believe most State laws referring to this subject contain the same provision. Indeed, in some States oleomargarine exposed for sale is required by law to be stained pink or some other color distinctive from yellow, and such a stain, while an actual adulteration, could not be classed as illegal.

There is still another form of fraud in food which may be defined as a negative adulteration. It consists in extracting from a food part of some valuable ingredient, and selling the residue as the genuine article. The sale of skimmed milk for whole milk, and of spent tea leaves for genuine leaves, are illustrations of this kind of fraud. Perhaps the best method of illustrating these various kinds of fraud and adulteration will be to call attention to some of the articles sophisticated in the ways described. No attempt, however, will be made to give a complete list of adulterated articles, for such a list would fill a volume. Attention, therefore, will be called only to the more important articles of food, and to those which are most commonly adulterated. In addition to this, examples will be given of some peculiar forms of adulteration which are little known to the public.

*Milk.*—Normal cow's milk should contain about three and one-half per cent. of butter fat, and should yield, on standing in a cool place for twenty-four hours, from ten to twenty per cent. by volume of cream. Until the establishment of milk inspection in cities, whole milk was something of a rarity. With careful inspection, such as obtains in Boston, the percentage of adulteration has been largely reduced.

An ingenious method of milk adulteration is sometimes practiced by the shrewd husbandman in such a way as to preserve his tender conscience from being seared. The cream in the cow's udder is naturally separated in part from the milk, unless the cow, just previous to milking, be subjected to violent exercise. The first milking, therefore, is less rich in butter fat, and it can be sent directly to the consumer. The last of the milking, called strippings, on the other hand, is nearly pure cream, and can be preserved

for butter-making. Butter fat, being lighter than whole milk, cannot be removed without increasing the density of the remainder above the normal. This density, however, can be reduced to the proper limit by the judicious addition of water. The testing of milk by the lactometer alone is therefore not a certain method of discriminating between a pure and an adulterated article.

Condensed milk is made by evaporating whole milk at a low temperature and in a high vacuum, in copper vessels, yet even at this low temperature some of the distinctive aroma of the milk is carried off by the escaping vapors. It therefore happens that even when evaporated milk is diluted to its original volume with water, it is never exactly itself again. Yet a pure condensed milk is not an adulterated article, for it is sold as condensed milk, and hence no fraud is practiced. When, on the contrary, as is often the case, sugar or salicylic acid is added in order more securely to preserve the condensed product, then a perfect case of adulteration is established. The manufacturer, however, may relieve himself of all responsibility, in so far as the addition of sugar is concerned, by stating on the label the amount added. In cases of deleterious preservatives, however, there would be no excuse. Their use in all cases should be prohibited.

*Butter.*—In regard to butter, the character of adulteration is well known. The use of oleomargarine as a butter substitute has been practiced for many years. The oleomargarine law, which imposes a tax of two cents a pound on the manufactured product, has not helped to restrict its use, but has rather increased it by giving to the consumer a guarantee of purity.

There can be no reasonable objection to the use of oleomargarine; it is clean, wholesome and digestible. When it is to be kept for a long time before use, as on ship board or in distant mining camps, it is preferable to butter, because it has but little tendency to become rancid.

*Lard.*—For similar reasons there can be no possible objection to the use of cotton-seed oil as a substitute for lard, or when mixed with lard, provided it be sold for what it is. Most of you are familiar with the great fight which was made against the use of the term "pure refined lard," which was the trade name of a mixture of lard stearine with cotton-seed oil. "Pure refined lard," it was claimed, was a term which had been used so long to designate the mixed product that it had become in reality a trade-mark, and was therefore entitled to respect and protection. In the investigation which was held before the Congressional committees, it appeared that as to the trade the contention was quite justifiable. Goods sold under that name were understood to be mixed. When, however, the mixed product was offered to the consumer, it was purchased with the idea which the name naturally implied, that an extra fine quality of hog's lard was secured.

All attempts to pass a pure lard bill, modelled on the Oleomargarine Act, have heretofore failed in Congress, but several of the States have prohibited the sale of mixed lard, except when offered under the proper name. Manufacturers have, therefore, been gradually forced to abandon the term "refined lard" when applied to this commodity.

I am of the opinion that many persons would prefer a cooking fat largely of vegetable origin to a pure animal product. To me it seems that some State Legislatures have taken a reprehensible course in prohibiting the sale of vegetable oils as a substitute for lard for cooking. The grower of hogs undoubtedly has a right to contend against the sale of vegetable oils as hog fat, but when he pushes his claim still further and demands that the markets be closed to products as pure and nutritious as his own, he passes beyond the bounds of public support. Every person in the United States who prefers cotton oil to lard should be allowed to purchase his supplies without let or hindrance. Every grower and maker of pure lard has the right to an equally open market, from which every adulterated and mixed lard, offered as pure, should be rigidly excluded.

For a time, a few years ago, when a popular fad prevailed in favor of nitrogenous foods, the true value of fats to the digestive and nutritive economy was not well appreciated. At the present day this is all changed, and we know how to value a fat properly.

It is therefore a matter of no mean importance to protect the public in the use of olive oil instead of cotton oil, of cotton oil instead of lard, and lard instead of a mixture of beef and cotton oil stearine. It is true that cotton oil, when carefully re-

fined, is almost as good a salad dressing as olive oil, but it is very much cheaper, and those who prefer to pay the high price should be secured against fraud. In respect of wholesomeness and digestibility it would be hard to choose wisely between the two.

One of the great difficulties in securing the enactment of a National Pure Food Bill has been the feeling in cotton-growing regions that such a bill would restrict the market for cotton oil. This is true if the fraudulent market is meant. By that I mean the surreptitious sale of cotton oil as olive oil and as lard. But such a bill would not interfere in the least with the legitimate market for this product. Cotton oil, as a food, has such merit of its own as to warrant the belief that it does not require any smuggling to secure for it a wide and rapidly increasing use. The South as well as the North would be the gainer from honest markets for honest foods, and it is such a short-sighted policy that leads to a crusade against such legislation as will secure the desired result. It would be a rather unfortunate thing for the whole country should an irrepressible conflict between the *sus* and the *gossipyum* keep our interstate market forever open to mixed or doubtful fats.

*Sugar.*—The common idea that the grocer puts sand in his sugar is not borne out by the facts in this country. I doubt whether a single pound of white sand has been put into the sugar supply of this country in the last ten years. It is one of those popular fallacies which gain credence inversely proportional to their truth. The granulated and white lump sugars which are found in our markets are almost absolutely pure; as pure indeed as the utmost care in manufacture can make them. Occasionally a little flour or starch may find its way into the powdered sugar, but such instances must be exceedingly rare. Low-grade sugars contain molasses and water as a result of the way in which they are made and dried. In the refiners, after the pure white sugar has been secured, the molasses therefrom is reboiled and a second crop of sugar crystals obtained. These form the so-called coffee sugars of commerce. In a like manner a third crop of rather light colored crystals may often be formed. By a combination of low temperature and high vacuum in boiling, and by a manipulation producing small crystals, a sugar can be made very soft, and, so prepared, it absorbs a good deal of the mother liquor in which its crystals grow. It is possible, in this way, to put on the market a fairly light-colored and attractive sugar, which may not contain more than eighty-five per cent. of pure sugar. This process of making low-grade sugars is practiced chiefly with the product of the sugar cane. In sugar from beets the molasses and mother liquors are usually so highly charged with alkaline salts as to render the manufacture of low-grade sugars, fit for table use, a very difficult matter. In this country, as is well known, the greater part of the sugar consumed is made from sugar cane. Of the 4,000,000,000 pounds which we have eaten in the last twelve months, probably 3,500,000,000 have been grown under tropical suns. The proportion of yellow, coffee, and low-grade sugars offered is therefore, greater in our markets than in Europe, where the sugar beet supplies nearly all of the sugar consumed.

*Syrups.*—In respect of molasses and syrups the bill of health is not quite so clean. The quantity of pure maple syrup sold annually is well calculated to make the maple forests of Vermont prick up their ears. A very little maple molasses mapleizes the whole jugful; a fact that makers and sellers have not been slow to learn. An extract of hickory bark imparts a misleading flavor to a syrup made from cane sugar and starch, and a patent has been granted by the United States protecting the discoverer of this process in the exercise of his invention. Judicious mixturer of glucose, sugar, syrup, and maple-flavor are the secrets of the marvelous expansiveness of maple molasses between the tree and the gullet.

"Golden drips," "honey syrups," etc., are names given to compounds made of refinery refuse, glucose and centrifugal cane molasses. The great base of all our table syrups is glucose made from corn starch. I am far from denouncing glucose as a dangerous ingredient in such mixtures. On the contrary, when glucose is properly made, it is both palatable and wholesome, but its sale as maple molasses or as refiner's syrup or as open kettle molasses is clearly fraudulent.

*Honey.*—Liquid honey is very largely adulterated with glucose. Of 500 samples of honey bought in fifteen large cities and

examined by the chemical division of the United States Department of Agriculture, nearly forty-five per cent. were found to be fraudulent. Of comb honey, only that is adulterated which comes in bottles or jars. A few years ago there was a popular impression, which I shared, to the effect that comb honey in the frame was adulterated; but no sample of this kind has ever come under my observation, and I am convinced that such a species of adulteration does not exist. Perhaps there is no class of food producers in the country whose business has been so seriously injured by adulteration as the bee growers. Many of them, however, do not seem to realize the magnitude of the frauds which are perpetrated against them. They have often been known to denounce, as attempts to injure their business, the statements that such frauds are practiced. Of late, since indubitable evidence of fraud has been presented to them, they have determined to use every means to end it.

*Coffee.*—Almost equally subject to adulteration is ground coffee. The high price of coffee is a special incentive to sophistication. In former days it was largely the custom to buy the green berry, and each consumer would do his own roasting. Now it is fashionable not only to buy the roasted berry, but also to buy it in a ground state. Chicory, roasted peas, beans, etc., are often found in large proportions in such preparations, and in fact it is somewhat rare to find a pure ground coffee. It might be held that such sophistication would end with the ground article, but such is not the case. The berries themselves have been imitated both in the green and in the roasted state. The moistened mass of chicory, starch, pea meal, caramel, molasses, etc., is moulded into the proper shape, and, when dried, these imitations might easily escape detection when mixed with the genuine berries. Those who are so fortunately situated as to be permitted to live at home and regale themselves each morning with an aromatic cup of Mocha or Java, scarcely realize what it means to drink a lukewarm concoction of chicory and pea meal, bluish black in color, but decidedly yellow in flavor.

*Tea.*—Thanks to our custom laws very little tea is found in this country adulterated with foreign leaves. The chief adulterations practiced with tea are found in the use of spent leaves, and in the practice of facing. The practice of facing consists in treating the leaves with some preparation designed either to increase their weight or to improve their appearance. Salts of iron or copper are often used for this purpose. Some of these facing materials are quite prejudicial to health, and such teas are best excluded from the breakfast table.

*Cocoa.*—Cocoa and chocolate are largely adulterated with starch and sugar, harmless in themselves, but far cheaper than the meat of the *cocoa theobroma.* The natural oil of the cocoa bean is also often extracted, and its place supplied by a cheaper fat or left without an oil. These various preparations are offered under fancy names and with wonderful claims of excellence. But in general we may say that the food value of a preparation is not much improved by having it digested before it is eaten. Yet often we see it claimed for a given mixture that it has had all of its difficultly digested components removed and that these are replaced by others with which the gastric juice can have a veritable picnic. The digestible cocoas often belong to this class, and, perchacne, may have little of the virtues of the original beans left in them.

*Canned Foods.*—Of canned foods I should like to say something, but it is difficult to select the little which can yet be said. First of all, the material of which the cans are composed is a matter to deserve attention. It is undoubtedly true that glass is the ideal substance for cans designed to preserve food products. But the first cost of these packages and the danger of breakage during filling and transportation, exclude them from competition with tin in all except the choicest brands of preserved foods. Fortunately, tin is a metal which is not only troublesome to the tariff but also resistant to most organic acids. It is acted on very slowly or not at all by most organic acids found in fruits, vegetables and meats. In some countries, such as Germany, the tin which is used in contact with canned foods is required to be almost pure, and to contain not more than one or two per cent. of lead. The most abundant adulteration of tin, as found in tin cans, is lead, and it is against the presence of lead that it is especially necessary to guard, inasmuch as the organic salts of lead, without exception, are poisonous. In

this country of personal liberty there is no restriction as to the percentage of lead which tins used for canned fruit may contain. We have found as high as twelve per cent. of lead in tin from cans which have contained food designed for consumption. Such a high percentage of this dangerous metal cannot fail to excite alarm. We have also found numerous evidences of erosion on the tinned surfaces exposed to the action of the contents of the can. The tact of the preserved goods with solder should also be carefully prevented, inasmuch as solder contains often as much as fifty per cent. of lead. It is very common, however, to find lumps of solder in the canned-goods and also to find the solder protruding through the points of union of the can and cover so as to be exposed to the action of the contents.

*Copper in Peas.* Equally objectionable is the habit of using copper salts to impart a bright green color to canned peas and other goods. The imported French peas are uniformly colored with copper. The addition of a little copper, in any vegetable which it is desired to keep green when served, has a happy effect in that direction, and fashionable cooks have not been slow to learn this. It is true that the quantity of copper which one would eat in a single meal where French peas are served, would not prove greatly injurious, but on that large part of our population who are compelled to dine every day on truffles and peas interspersed with terrapin and champagne, there is great danger of the copper acting with accumalative effect.

I have already spoken of the danger which may lurk in preservatives, such as salicylic acid, but there is also an occassional source of danger in the development of nitrogenous bodies called ptomaines in preserved meats. These bodies may develop with astounding rapidity if a can of meat be opened, and not eaten for a day or two. An illustration of the fatility of the action of such bodies is unfortunately often found in the case of tyroxicon, a poison often developed in milk or cream.

The above will serve as illustrations of the more common forms of adulteration to which our foods are subjected. The idea might be formed from this array of facts that foods are almost all adulterated, and that it is extremely difficult to obtain anything pure. Newspapers love to magnify these accounts of adulteration. What I have placed before you has not been for the purpose of exciting a panic on the subject of foods. Much the greater part of foods which Americans eat is pure and wholesome. It is only the small quantity of adulterated food from which we should strive to protect ourselves.

The popular idea of adulteration is really very much at fault, and this has been due largely to the exaggerated statements of presumably honest men, who desire to call attention to the fraud and to prevent it by exciting the popular mind against it. The adulteration of our foods and drugs is certainly bad enough, but in my mind it does no good whatever to exaggerate, falsify and misstate the results of careful and unbiased investigations. As has before been intimated, in this address, the remedy against all these things lies clearly in the power of the people. Wise laws wisely administered, a careful system of inspection, a demand for pure food, will secure the people in their right. It is not the rich for whom we should work, but the poor, and they should be protected against frauds in food ; frauds not so dangerous on account of being deleterious to health as because of their pretensions to furnish to the poorer part of our people a food ostensibly pure and nutritious but in reality valueless. It is not supposed for a moment that any system of legislation can entirely prevent the perpetration of frauds upon the community, but at least these crimes can be made punishable and their perpetrators may be compelled to endure the penalty of their misdeeds.

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Dr von Blarcom, one of the most distinguished physicians in Berlin, expresses the opinion after careful investigation that coffee long boiled produces more indigestion than any other substances taken into the human stomach, and that a simple infusion facilitates digestion.—*Public Opinion.*

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It appears as if the people of the United States were steadily reducing their consumption of quinine and other cinchona alkaloids. Year after year since 1887 the importance of cinchona bark have been diminished. In 1893 the amount imported was less than half that of 1887.—*Popular Science News.*

# TRANSLATIONS.

## INFLUENCE OF GONORRHŒA IN THE PUERPERIUM AND DISEASES OF THE EYE IN THE NEW-BORN.*

Dr. Richard v. Steinbüchel has collected for his studies 313 cases, with as many new-born infants. The diagnosis of gonorrhœa in the mothers was based principally upon the clinical symptoms, which the author regarded as more readily depended upon than the study of the gonococci. He states that while the gonococci are present, as a rule, in gonorrhœa, they may be absent in typical cases for a few days, after which they are often seen again in greater quantities, thereby making a diagnosis based upon microscopical or bacteriological investigations more difficult than by the clinical method.

His diagnoses are based principally upon the methods of Sanger:—

1. The existence of slight catarrh of the urinary passages containing pus cells.
2. The demonstration of pus in the urinary passages, as also the deeply reddened and swollen margins of the urethral mucous membrane.
3. Inflammation of the Bartholinian glands, having the appearance of a dark purple ring around the opening of the glands (macula gonorrhoica.)
4. Condylomatous points at the vulva, vagina or cervix.
5. A purulent or muco-purulent discharge from the cervix connected with an erosion of the os.

Having made the diagnosis of gonorrhœa in the mother, principally based upon clinical facts, the rule was to prevent, if possible, the entrance of the gonococci, usually present in the vaginal discharges, from entering into the eyes of the new-born. Of 313 new born there were 13 suffering from some affection of the eyes; of these, 9 were not virulent; 4 were of the blenorrhaic type. Of the 4 children suffering from blenorrhœa, 1 was found to belong to a mother who was not suffering from gonorrhœa, hence the child must have been infected after birth. The low percentage (4 cases of ophthalmia, 1.28 per cent. from 70 mothers suffering from gonorrhœa equalling 21 per cent.) may be due to the use of Crede's method, which is often left in inexperienced hands.

The influence of gonorrhœa upon the puerperium could be studied by the author only during the interim of 8 days after the confinement, since the patients were usually transferred after that to another department; S. concludes from observations made during this time that this disease did not have any marked influence on puerperal diseases in general. Seven of the gonorrhœal patients had a rise of temperature in the first 8 days (10 per cent.) while the rise of temperature in those not suffering from gonorrhœa was 9 per cent. as a rule. The first group contained one fatal case, and the second two, caused by sepsis (due to an epidemic of erysipelas, the hospital contained no room for isolation.)

After some energetic investigations into the subsequent histories of some of these above mentioned cases, S. traced eight. Six of these were grave affections of the tubes, ovaries, and peritoneum. The first symptoms set in between 3 to 12 weeks. The author states that the lochial discharge carrying with it, as it often does, shreds of mucous membrane, may be the cause of the delay of active symptoms, which he proves by the facts that as soon as the discharge ceases and the involution progresses the symptoms of the gonorrhœal infection become more marked. —*Deutsche Med. Zeitung*, March, 1894.

—W.

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THE Zoothermic Institute in Rome is a "cure" place, where people go to drink fresh blood for the cure of gout, rheumatism and the great prostration and anæmia caused by the malarial fevers of the Tontine Marshes. The blood to be imbibed is first rapidly freed from fibrin by a carefully aseptic method, the animals from which it is derived having previously undergone inspection by a veterinary surgeon. Some patients bathe either a part or the whole of the body in the warm blood, and the Italian doctors think, with great benefit.—*New York Independent.*

* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

## THE FINAL RESULTS FOLLOWING THE EXTIRPATION OF THE ASTRAGALUS FOR THE TREATMENT OF THE VARIOUS FORMS OF CLUB-FOOT.

In a monograph on this subject, J. G. Gohl considers at length the etiology of this affliction in its various forms. In the case of a congenital club-foot of aggravated form, the wound healed, without any complication, within five days. The patients were permitted to make some efforts in walking and succeeded so well that at the end of fifty days they were discharged cured, any external support being deemed unnecessary after that time.

(One of the two cases—pes varus congenitus duplex—in which extirpation of the astragalus, a portion of the calcaneous and cuboid, necrosis of the toes and the metatarsus set in.)

In those cases in which paralysis existed, due to disturbed functions of the muscles, it was always deemed necessary to improve the patient's general health in order to insure a rapid and healthy union of the surfaces operated upon. The usual time between operation and discharge was between fifty to sixty days. The immediate results of the two cases belonging to the cicatricial variety were perfect, but it was impossible to make any statement regarding their permanent cure since both died by some intercurrent disease.

The desirable feature in this operation is that there is no need for the usual after treatment with external supports. It is necessary to begin early with passive, and later active motion followed by massage—a firm support for the ankle is needed only immediately after the operation in order to sustain the still somewhat weakened joint. The greatest care should be exercised in sustaining the ankle by properly selected shoes.

The excision of the bones produce but a slight degree of shortening and may be readily overcome by thicker soled shoes. There are a number of plates showing casts of feet, before and after the operations.—*Centralb f. Chirurg.*, No. 8, 1894, It may be interesting to add in connection with this that Dr. Thos. G. Morton, of Philadelphia, has operated on about thirty cases in much the same manner, taking great care to remove all the bony obstructions to insure a thorough correction of the deformity, having preceded this by a tenotomy of all the flexors and extensors which seemed to require it. All the cases made an uninterrupted recovery, and were thoroughly and permanently cured.—M. B. W.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### PICRIC ACID IN SUPERFICIAL BURNS.

Dr. P. Filleul, (*La Semaine Médicale*, No. 7, 1894) states that at the Hôspital de la Charité in Paris, picric acid has been employed with success for several years in the treatment of superficial burns. A saturated solution is applied on gauze compresses; they must be carefully wrung dry before they are laid on, and if the dressing remain antiseptic, it does not require to be changed frequently; at first every three days and then every four, five or six days. No impermeable protective is necessary for they are simply allowed to dry on the burn. Besides being antiseptic and healing it also calms the pain. There is no danger of poisoning, of irritation of the skin, nor of any other disagreeable side-action. The only disadvantage is the yellowish discoloration of the parts with which it comes in contact.

*In charge of the translator, F. H. Pritchard, M. A., M. D.

### SUBLIMED SULPHUR IN DIPHTHERIA.

Dr. Baeumler (*Muenchener Med. Wochenschrift*, No. 10, 1894) recommends sublimed sulphur in the treatment of diphtheria from the results obtained in an experience of over seven years. The powder is applied to the affected parts, at first, every one to two hours and eventually every three to four times a day, by means of a large and soft camel's hair brush; during the intervals, a weak solution of permanganate of potash is used as a gargle. The results of this treatment

were better than those obtained with previous methods. Even severe cases, with extensive gangrene of the soft palate, often pursued a favorable course. He advises an extensive employment of sulphur in this disease.

### IODINE IN ACTINOMYCOSIS.

Dr. Ostertag (*Deutsche Med. Wochenschrift*, No. 9, 1894) thinks that the treatment of actinomycosis by the iodides as recommended by Thomassen, has not met with the recognition that it deserves. He concludes from his experience as well as from that of others, that iodine is an actual specific in this disease. In the treatment of cutaneous and subcutaneous actinomycotic growths, a deep crucial incision was made and the hardened tissues painted, once a day, with the tincture of iodine. Internally iodide of potash was given in aqueous solution, once or twice a day. In two to four weeks recovery would follow. Bass, Fuertmayer, de Jong and others have also obtained similar results. The result was analogous to that seen in gummatous tumors after administration of the iodide.

### ETHER LOCALLY IN INCARCERATED INGUINAL AND FEMORAL HERNIÆ.

Dr. Lyncker (*Wiener Med. Presse*, No. 12, 1894) has used ether locally, for the last five years in the treatment of severe cases of incarceration in inguinal and femoral herniæ and has not been obliged to resort to surgical measures even in the severest cases. If reduction was found impossible, an injection of morphine was given and every quarter to half hour, a teaspoonful of ether slowly poured onto the hernial tumor. In thirty cases treated thus painless reduction was possible even after incarceration had existed for several days and the hernia was large. He can only recommend this method most heartily. (An injection of atropine and morphine into the region of the ring with elevation of the pelvis is also an excellent proceedure; Gussenbauer advises also the local application of ether, but with elevation of the pelvis, which latter measure is of itself of value.)

### GUAIACOL IN DIABETES AND THE POLYURIA OF DIABETES.

Dr. T. Clemens (*Wiener Med. Presse*, No. 5, 1894) praises the action of guaiacol in the treatment of diabetes and the associated polyuria. The dose of the (pure) drug was three to six to ten drops, three a times day, in a tablespoonful of milk, or, if tolerated, in an eggcupful of cod-liver oil. In order to control its influence he did not order any special diet and examined the urine, passed after dinner, on several consecutive days. After the patient had taken the drug for eight days his urine which usually contained from 1.86–2.90 per cent. of sugar, in the afternoon, showed a very considerable reduction; in some cases the sugar was only present in a very slight quantity, in a few entirely lacking. After it had been taken for two to four weeks, here and there, a few sweet foods containing sugar could be allowed without influencing the amount of sugar in the urine. A still more striking action was observed in the polyuria of diabetics. In some cases, in eight days the quantity of urine was reduced by half. This was controlled by discontinuing and reducing the dose of the drug. In all cases the general condition was improved while the remedy was well borne.

### PIN WORMS.

Dr. Etter (*Norsk Magazin for Laegevidenskaben*, No. 1, 1894) claims that the best remedy for pin worms is to catch them. In the evening at about bedtime when these worms take their evening promenade the patient should be placed in the knee-elbow position, the anal folds separated and the active little creatures be caught with a small pair of forceps. The first day will yield the best results but one should not discontinue the search too early even though no worms have been seen for several evenings.

### SYPHILITIC INTERCOSTAL NEURALGIA.

Dr. Obolenski (*Medicinische Neuigkeiten*, No. 9, 1894) reports several cases of intercostal neuralgia of a syphilitic origin. Diagnosis was made by exclusion and confirmed by the immediate and rapid results obtained with mercury. As characteristics, he calls attention to the bilateral appearance of the pains, their setting in or becoming more pronounced during the night and their aggravation at night—osteocopic pains.

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SATURDAY, APRIL 21, 1894.


## EDITORIAL.

### A NATIONAL DEPARTMENT OF PUBLIC HEALTH.

Elsewhere in this number will be found in full the text of a bill prepared by a special committee of The American Medical Association, together with the memorial framed to introduce the bill to the National Senate and House.

The memorial intimates some excellent reasons for the enactment of the bill, but we are inclined to think that the petition, although exhausting, is couched in terms too general to avail much with the average law-maker. The improvements desired involve some radical measures. It asks for the establishment of a Federal Department of Health with an executive head who shall be a member of the Presedent's Cabinet, the peer of all other members of that body. In our opinion the bill is reasonable, wise, beneficent and timely. It seeks the formation of the department on a very broad basis but leaves the details of organization and development to be worked out by the department itself within limits abundantly wide and at the same time distinctive. A reading of the proposed measure will commend it to everyone as a righteous and necessary act of public policy and one calculated to greatly enhance the well being of the citizen himself. Senator Sherman is expected to introduce the subject in the upper house, while Mr. McCreary of Kentucky, will present it to the House of Representatives.

Meantime another and much inferior bill, engineered by the New York Academy of Medicine, has already been introduced to the House and by it referred to the Committee on Interstate Commerce, before whom advocates of the measure were given a hearing at Washington, D. C., on March 28th. According to the New York *Medical Record*, "short addresses in favor of the bill were made by Drs. T. Gaillard Thomas, Richard H. Derby, J. H. Girdner, George F. Shrady and T. Mitchell Prudden, of New York, Professor William H. Welch, and President Gilman, of Johns Hopkins University, and by Dr. Rohé, of Baltimore, representing the National Bu-

reau of Health Committee of the Medico-Chirurgical Faculty of Maryland. The speakers were most attentively heard by the Congressional Committee, and much interest was manifested in the purposes of the bill."

Marked inferiority of this latter bill will be made evident by comparing the measure proposed by American Medical Association with the following:

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ANALYSIS OF PUBLIC HEALTH BILL PROPOSED BY NEW YORK ACADEMY OF MEDICINE—BUREAU OF PUBLIC HEALTH.

The Bureau. Two Commissioners-at-Large; nine District Commissioners; four Ex Officio Commissioners.

Officers elected by Bureau. President and Vice-President, to be elected from Commissioners-at-Large (outside Secretary).

Compensation. President, ($15 per day; all other Commissioners, ($10 per day; Secretary, $3,000 per year.

Executive Committee. The President and the four ex-officio Commissioners.

Duties of the Bureau. Make rules for duties of Executive Committee; make rules for guidance of Bureau and employes, establish rules for government of National sanitation, foreign and Inter-State special departments; may call conference with State Boards.

SECTIONS 5, 6, and 7. Collect and diffuse information; advise the Departments of Government, Executives of the several States, all Health Authorities when called for, or when the Bureau thinks best, to to secure sanitary condition of vessels from foreign ports; to prevent the introduction of contagious and infectious diseases and their spread, and to be the Government medium for National sanitary action; may make investigations abroad, and the President of the United States may, on request, detail officers from the several Departments of the Government.

SEC. 8. Shall report facts to Secretary of Treasury.

SEC. 9 and 10. Shall obtain information of sanitary condition of foreign countries from Consuls and from domestic sanitary authorities, and transmit same to various public and State officers.

SEC. 11 (dup. of Sec. 6). Shall furnish information and advice to States and Government Departments when requested.

SEC. 12. Shall co-operate with State authorities and secure uniform system of notification.

SEC. 13. Shall make rules for vessels engaged in foreign trade.

SEC. 14. Shall issue rules and regulations to Consuls.

SEC. 18 and 19. Shall have authority to forbid entry of vessels under certain specified conditions, and may order vessels to quarantine; may send to National or State quarantine in case of epidemic.

SEC. 20. May exercise Inter-State quarantine authority.

SEC. 21 and 22. Provides for purchase of State quarantines.

SEC. 25. Shall make an annual report, and its correspondents may have franking privilege one million appropriations. District Commissioners, Sec. 8. Examine into health measures employed in respective districts, and report same to Bureau, and thereafter make annual reports of sanitary affairs of his district.

Surgeon General of the Army, execute all orders, rules and regulations relating to sanitation in his branch of the Public Service.

Surgeon General of the Navy. Same as above.

Surgeon General Marine Hospital Service. Perform all duties in respect to quarantine and quarantine regulations provided by this Act."

This analysis was made of the original proposition of the New York Academy of Medicine, which, however, latterly withdrew the original bill providing for sanitary districts, and substituted a very much better one, but retaining the great defect of organizing as a "Bureau" in an already existing Department. It would seem that the latter measure could be advocated only on the grounds of expediency—that half a loaf of bread is better than none at all.

The REPORTER does not anticipate any action on either of these measures by the present congress. Because the measure is non-partisan, non-sectional, is not rendered absolutely compulsory by the imme-

diate pressure of public opinion, and principally because it is pure common-sense. A glance at the Capitol shows the House striving to solve the arithmetical problem of counting a quorum and each time obtaining a result which fails to prove by the test of "a call of the House," while the Senate is agonizing in the throes of the second stage of a parturition, complicated by a cross-presentation and showing every sign of impending eclampsia. It would be folly to expect our legislators to pause in the manipulation of these most important projects long enough to consider a measure whose prime recommendations are its utility and wisdom.

But the energy thus expended is not wasted, for we can bring greater pressure to bear each time we repeat the effort, until we eventually succeed as we will. In the meantime public opinion will grow stronger and stronger as it appreciates the value of the object lessons presented by the various State Boards of Health, many of which are doing most efficient service within the limit of their powers, thus giving incontrovertible evidence of what can be accomplished by such a body invested with national powers and authority.

A very great impetus can be given this most desirable movement if medical societies will officially express their approval and urge upon Congress the establishment and equipment of a Department of Public Health on a parity with the other governmental departments.

# ABSTRACTS.

## A PETITION TO ESTABLISH A DEPARTMENT AND A SECRETARY OF PUBLIC HEALTH.

*To the Honorable the President of the Senate and the Speaker of the House of Representatives of the Congress of the United States of America.*

The American Medical Association at its meeting at Washington in May, 1891, adopted unanimously this resolution:

"*Resolved*, That the President of the Association. W. T. Briggs of Tennessee, appoint a committee to memorialize the next Congress to create a Department and a Secretary of Public Health."

At the meeting of the Fifty-second Congress in December, 1891, a petition and a bill to that effect were introduced in both Houses; in the Senate by the Hon. John Sherman, and in the House by the Hon. John A. Caldwell, and they were referred to certain committees. No report has ever been made to either House on the subject.

At the annual meeting of said Association in the City of Detroit in June, 1892, the Committee reported the failure to secure any action of Congress on the petition; whereupon the Association again directed the select committee to renew its appeal for Congressional action; but no notice was taken of it, chiefly because the alarm at the approach of cholera from Europe led Congress at once to enlarge the existing quarantine system which it was supposed would answer all purposes.

The Chairman of the Committee addressed a communication to the Chairman of the Committee on Contagious Diseases in the Senate, which set forth that while the quarantine measures were very effective so far as the hindrance to transplanting the disease of other lands were concerned; yet they did not include all the measures for the operation of preventive medicine which the American Medical Association was seeking to establish for the public welfare.

The only answer made at any time by this gentleman was merely verbal, and that it was his belief that Congress would not appropriate money that would increase public expenditure.

At the annual session in Milwaukee in June, 1893, these facts were reported, and the Special Committee was ordered to renew the appeal at the approaching Fifty-third Congress. Under this authority

the undersigned beg your consideration of the whole subject anew.

In the Pan-American Medical Congress, which met in Washington in September, 1893, under the auspices of our Government, the most august assembly of medical men that ever met in this hemisphere, this question was carefully discussed and unanimously approved. Moreover, a large number of State Boards of Health, the National Board of Public Health and numerous medical societies in different cities and States have given their adhesion to this movement.

The American Medical Association is constituted of men of distinction in every part of the Union. For more than forty years its sessions have been held in the chief cities of the States lying between the Atlantic and Pacific coasts, and it represents nearly one hundred thousand intelligent and well-known citizens. The annual sessions have greatly promoted scientific research into the causes and treatment of diseases of every character, the formation of State Boards of Health, higher medical education and the publication of treatises on preventive medicine and medical practice which forms a continuous line of medical progress in the last half of this century.

The Government, through the operations of the Surgeons-General of the Army, Navy and Marine Hospital service has made liberal expenditures for the National Medical Library and its Index Catalogue, a Pathological Museum and some investigations on the origin, nature and spread of the fearful infectious germs that are brought to us by immigrant and other ships. But the medical profession believes that the Government can, in a wider way, promote the public welfare by creating a Department of Public Health, the head of which should be a physician, a member of the Cabinet and on a parity with the heads of the Departments of War, Navy, Finance, Justice, Agriculture, etc. A fair investigation will show that no profession excels ours in positive efficiency to sustain public order, public comfort and public virtue.

Hygienic science, on the one hand, and the progress of the sciences and growth of the mind, on the other, have always been powerful factors in the evolution of humanity. In the first century, when Rome had reached her apogee in power and civilization, and had constructed great aqueducts, public fountains, public latrines, gymnasiæ and a vast system of sewers, under the suggestions of physicians, Martial said that it was not merely a question of living, for the people, but to have good health; hence the maxim that has come down to us: "The health of the people is the supreme law."

Recently, the Lord Chancellor of England, appointed Sir James Crichton Browne, M. D., LL.D., as his visitor to make certain investigations in regard to the public health, and of the influence of certain employments upon the health, and comfort of the laboring classes. We can only give a partial exhibit of his observations. He found, that while the decline in the death rate at all ages had been, within a certain period, 17.5 per cent. in those under 55 years of age, it had been reduced only 2.7 per cent. in those above 50 years old. The increased longevity has occurred under the age of 35. The decline in the death rate beyond the age of 45 had been insignificant, but from 65 to 75, the death rate was increased. He adds that it is not satisfactory to learn that while there has been an enormous increase in the duration of life in babies and young people, the loss is alarming among those who are eminent in experience and judgment. The causes of this vital failure in the mature element of society was not difficult to find by his statistical studies. In three or four groups of diseases a marked increase in mortality has taken place; thus, in England and Wales, cancer in five years, from 1859 to 1863, carried off 35,654, while in five years from 1884 to 1889, the deaths by cancer were 81,620 an increase of 120 per cent. The increase in deaths by nervous diseases in the same period was 38 per cent.; in kidney diseases for the same period the increase in deaths was 164 per cent.; in heart diseases, the increase was 143 per cent. These affections, he continues, are of degenerative character and largely may be traced to vital abuse, over strain and the increasing luxuriousness in our advancing civilization which establish premature senility. Moreover, the large increase in insanity is causing solicitude everywhere. It cannot be questioned that this fearful increase in bodily and mental decay should be well understood by and placed before the people. There is another

phase of this question of premature decay of great interest and it concerns a burning question of the day. Sir James says, that owing to the strain and drive, in many manufactories where handicraft piecework prevails, the neuro-muscular systems of the shoulder, arm and hand which on the average attain maturity at 30 years, and should continue as much longer, begin to fail at 45 years, and while at 30 a man can earn 45 shillings a week, at 45, strive as he may, he cannot earn over 38 shillings, and at 55 his earnings fall to 24 shillings, owing to the premature decay of the motor apparatus from overwork. In Sheffield he fonnd that penknife makers aged 30 years, strike 28,000 blows a day with a hammer, but at 45, they find their celerity and skill have declined to nearly one-half, and a reduction in wages to the same extent ensues.

As we have no national office for the collection of such statistics, except perhaps the Bureau of Labor in a partial way, we must rely upon those furnished by other nations.

The telegraph operators, everywhere, sooner or latter become the victims of scrivener's palsy of the fore-arm and fingers on account of the excessive use they are obliged to make of them, for, as their celerity fails their wages decline. The mail clerks on railroad trains are required to work many hours more than in other Government offices, and are besides compelled to memorize, with all the certainty of the multiplication table, the locality of eight to ten thousand post offices in the vast districts of the country. The effect in numerous cases of this excessive use of the memory is insomnia and a mild form of dementia. It is, certainly, a function of statesmanship to investigate these serious evils. The Government has begun to investigate the exposure of employes on railroads who are often wounded and killed in the coupling of cars; and the investigation of the desperate use of young people in the "sweat shops" of clothing establishments has created a great outcry for their relief.

"In 1848 the Public Health bills in England went into operation. The annual death-rate which up to that time was 22.5 per thousand diminished to 17.9 per thousand within twenty-years; showing a saving in that time of 125,000 lives. The effect of hygienic measures in preventing sickness is well known in the State of Michigan. During the year 1889 there were 417 outbreaks of scarlet fever. In seventy-two of these outbreaks, isolation and disinfection were neglected and the number of cases, per outbreak, was 16.78 per cent. In fifty-two outbreaks, both isolation and disinfection were strictly enforced with the result of limiting the number of cases to 2.67 per cent. In many outbreaks only one restrictive measure was used and the other neglected, and in all such cases there was some reduction in cases, but never to the same extent as when both were enforced." (Dr. J. W. Brannan, *New York Medical Record.*)

Our census of 1890 shows that 524,000 deaths occurred in that year, and that 100,000 were from consumption. It is estimated that about one-half the whole number was due to diseases that could have been prevented.

It is now becoming generally known that infectious diseases and toxic elements are disseminated in food. An infectious disease in the family of a dairyman, or among his cattle, may be as widely spread as is the distribution of his milk. The pollution of streams supplying towns, cities, and wells of water at farmers' homes, we know, definitely, subject the people to tedious and fatal diseases which a wise sanitation would prevent. It is absolutely demonstrated that by the rigid application of hygienic measures the ravages of a pestilence may be stayed. Medical scientists speak of such destruction as a self-imposed curse of dying in the prime of life.

In primitive history we find that hygeia and therapy were the conservative and remedial agencies of afflicted peoples. We read with admiration of the wisdom which made sanitary measures a part of the religious codes of a nation. The hygienic laws of Moses, which undoubtedly embody fragments of his Egyptian training both as a physician and a priest, and the moral law, the Ten Commandments, received from the hand of God, have been kept together by the Jews in their sacred books and inculcated in their religious and social rites for thousands of years, which clearly accounts for their existence, physically and mentally, as one of the most vigorous races among the multitudes of the earth.

Physicians are held to be the guardians of the organs that concur for the maintenance of a healthy animal life, but it is not so generally understood that the great brain, the physical basis of the mind, is just as much an organ of their conservative regard; it is not so well known that the healthy brain is necessary to a free will—the function that places man in his supreme condition as master of created things.

The increased light which physiology and pathology have shed upon the relations of the brain and mind, has enabled us to locate the area in the brain where exists the capacity to think, where sensations are shaped into concepts, where ideas are symbolized in language, where memory holds its seat, the imagination displays its marvellous powers, and self-control is enthroned. All of the apparatus of our mere animal life—respiration, circulation of the blood, digestion and assimilation of food, excretions of waste tissues and the actions of the nervous and muscular systems are to maintain and develop in perfect health an area which we can cover with our two hands. It is the region of self-consciousness, the plane where spirit and matter are in impact and which enables a man to say: "I know that I know, I feel that I feel, I think that I think;" it is there, indeed, that consciousness feels itself to be coterminate with the cosmos. Who but the physician has the right to supervise this dread region? Closer than the minister of religion, or the rights of family, he stands as the guardian and interpreter of its illimitable faculties.

By prolonged physiologic and pathologic research, psychology has been lifted above the mere subtle reason of the schoolmen into the light of a new day, and is now comprehended as never before. Metaphysics is no longer a mere jugglery with words and phrases, but a function of consciousness only existing in the healthy area above described; it is the highest expression of reason, whereby the intuitional phenomena of thought and the phenomena derived from the senses, the ideal and the real, the subject and the object, the me and the not me, are brought by a free will into accord and the consciousness is freed from the baleful illusions, hallucinations and delusions which exist in the insane. The imperfect state of consciousness in unsound sleep, illustrates a mental state wherein ideas flow freely, regulated only by automatic association; we are led everywhere by the most grotesque and often fearful ideation, without any self-control; the metaphysical function is in abeyance; there is no metaphysics in dreams, the consciousness is on too low a plane for any exercise of the will. This argument is legitimate and should be convincing, that medical men hold an indispensable relation to the social and political state.

All abuses of the appetite in any direction, all violence done to the brain by overwork, overstrain, the excitement of narcotics, and the delirious speculative ventures in the values of stocks and of the products of the crops; everything, indeed, that keeps up, unduly, mental excitement, deteriorates at length the organic structures of the brain, enfeebles the mind in judgment on any subject; in short, a condition of dementia supervenes. It is for the physician to warn teachers of the deleterious effects of overtasking scholars; to warn people against luxuriousness, indolence, and the habitual use of stimulants, and excess in any passion or appetite; for, while the organs of mere animal life are damaged the nutrition of the brain is changed, the will becomes so impaired that self-control is lost. It is appalling to contemplate the social destruction about us on account of the prevalence of the passions of avarice, peculation and lust which so greatly defile public virtue. These are evils the indulgence of which has ruined statesmen and empires. Luxury and vice in combination form the dynamite in the moral world.

The medical supervision should begin in the primary and intermediate schools, which are frequently in overcrowded, ill-lighted and ill-ventilated rooms; this has become so serious that in Germany, at least, it has brought about State interference, and physicians must be consulted in regard to the hygienic properties of a schoolhouse. The physical structure of the eye is most liable to evil changes, leading to short-sightedness; and the organic life of the brain substance is exposed to deterioration leading to lowering of the intellectual faculties. In the technological schools of France the use of tobacco is forbidden, because it has been ascertained that its abuse renders the student incapable o

solving the highest problems in mathematics. It is also of great importance that the methods of teaching should not involve an excessive abuse of the memory —the *memoriter* plan. This it is thought is too greatly employed in American schools, but it seems to be a necessity so long as the rank of a pupil in his class depends upon the rate per cent. of correct answers. The abuse of the memory fatigues the brain as physicians well know, and impairs the power of the free will. Lessons are memorized, and not acquired by efforts of the understanding, hence they are not well retained and furnish a poor basis for intellectual ability. Not only so, but the emotional conditions so often encountered, and the startling phenomena of hysteria and hypnotism are thus often superinduced. There are no fortuitous conditions that concur for the production of the best moral and political circumstances of society; the whole is purposive intelligence existing in the individual and combined in the exigencies of the family and the State. Wherever the highest development of physical health exists, there will be found the surest basis of intellectual life. These are not abstract questions of philosophy but are the most practical questions of our times.

A candid and broad investigation of the medical profession shows that it appertains to the most important functions in the commonwealth. A distinguish English writer has said: "I think it will be well for the state when the medical profession is represented in the councils of the nation as weightily as can be assured by official places and conferred dignities." An eminent German economist has said: "We must look to the medical men to resuscitate society." There are no evils in society which physicians may not do much to avert; there are no foes of human happiness so widespread, miserable and despairing as those which underlie public health; and physicians are the only hope of public relief.

It is certainly a remarkable spectacle, the constant efforts of physicians to save the people from outbreaks of disease, when success will limit to the smallest dimensions our practice and incomes. But this arises from the nature of our studies whose tendencies are to render an unselfish service to humanity in the time of its calamities. The physician is bound to render services to the poor, especially. The amount of gratuitous service in great cities is a very large part of their practice. In all of our public general hospitals they serve without salaries.

If there were cruelties to prisoners on either side in our civil war, it was not perpetrated by the surgeons of the opposing armies. When the strife ceased they were the first to extend the fraternal hand across the red fields of conflict.

The progress of medical science establishes our increasing responsibility to place our medical schools on the highest plane of teaching. There is a very large aspect of medicine that renders it so commonplace as practically to degrade it, and this is a consideration that will be a great obstacle in the way to your adoption of our bill. I allude to the giving of drugs by everybody for the relief of symptoms of disease. It may be said all the people, young and old, not only offer general advice, but specify the remedies to be used. If medicine has no other basis than prescribing, it would possess no autonomy, embody no science, nor philosophic spirit; it would only become an unstable empiricism and would be abandoned to a revolting charlatanism and its practioners be mere vendors of secret, false remedies, and, as is now so largely done, would rob the sick not only of their money but of any hope of relief.

The human frame is said to be the Divine idea of mechanism, and nothing in all the works of creation so completely illustrates in its structure what is called by geometers the "principle of least action," that is, the greatest competency in function, with the least expenditure of material. Its figure, symmetry, mechanical, physical, chemical and biological forces are so correlated that it fulfills all the conditions of adjusting internal to external relations. Its organs of special sense, its area of consciousnese wherein it is the equipoise of the physical creation, justifies the ascription that man is the crown and flower of creation. Can any one doubt that it is only by a long and minute study that such an organism can be comprehended? Congress appropriates annually more than a million of dollars for the maintenance of military and naval schools, where the whole range of sciences are inculcated to ascertain the most ap-

proved methods of public defense and of killing our enemies. Can it be thought that any less science is needed to ascertain how to destroy myriads of enemies that provoke disease, and all the more terrible because invisible to common sight; and to save from death the most precious objects of human love and solicitude? Are there more scientific problems for solution in war by sea, or land, than those that exist in the grievances of our social life?

But we are not asking Congress to build a great medical school of instruction. Congress appropriates willingly large sums for the study of the diseases of cattle and plants, but comparatively nothing for the diseases of the people. But we show you that 522,000 inhabitants died in 1890, and that 250,000 of them at least, have perished by diseases which are preventable!

We ask for a Governmental Department of Public Health; one of whose functions would be the combination of the intelligence, feeling and force of all the schools and medical societies of the nation for collective investigation in order that physicians may become capable to the utmost, to relieve the woe and agony of suffering individuals and families.

For the medical profession to be able to exert all its benign influences in society, it must have the same rank and dignity that is attached to other Departments in the President's Cabinet. The methods of research are the same as those employed by other scientists. The methods of the calculus that are employed to ascertain the cause of the perturbations of celestial bodies, are the same as those employed in the investigation of obscure diseases. The physician is guided in his investigations by the canons of logic, and hence it is that the opinions of well-trained doctors are as reliable and stable as those of jurists, statesmen, engineers, merchants, divines, lawyers and political economists. The same reproach applied to doctors because of their different opinions, applies equally well to all other callings.

At this time the success in medical practice surpasses any other period of its history. The death rate in our general hospitals was never as low. In surgery it is about 3 per cent.; thousands of successive births take place in maternity hospitals, without a single death; the mortality in typhoid fever is about 3 per cent. in hospital practice; in general medicine the rate is declining; but it is not so low as in surgery because of the increasing mortality, as before said, in such diseases as consumption, cancer, kidney, heart affections, and the continued bad hygienic conditions in the congested areas of our large cities, where one-half the children die under five years of age. (Cincinnati Hospital Report, 1893).

The influence of medical culture upon the progress of civilization as before said, both in ancient and modern times forms a great chapter in human history. The evolution of the mind and the achievements in philosophy are no more marvelous than what is seen in preventive and clinical medicine. The chief figure in the most brilliant era of Greek civilization was Aristotle. He was of the Esculapian caste and took up the profession of his father, a practitioner of medicine; but his constant dissection of animals and plants aroused a philosophic spirit of seeking behind all the phenomena of nature by synthetic formula, the unity of all living beings and their indissoluble relation to the cosmos.

We can not, in our space, point out all the achievements of his immense genius nor his specific work in detail that entered into his purpose of constructing the edifice of inductive philosophy. Mere fragments of his precious writings were the only intellectual food (excluding the canon of sacred Scripture and the liturgies of the Church) of the Dark Ages; but when at last the chief of his philosophic works were collected and translated into Latin, the dawn of the revival flushed the skies and the sun of a new mental life shone in full strength upon the scholastic world, —the church adopted his philosophy and the renaissance was complete. The influence of Aristotle has continued to direct modern thought, and though much of it has been laid aside, his inductive philosophy and logical methods are invincible.

In Europe, medical affairs have always had the watchful care of the state, and eminent practitioners are now more than ever before, receiving titles of distinction. In Italy a physician holds a Cabinet Secretaryship, and in the Parliaments, everywhere, distinguished practitioners are taking part in general statesmanship. Without the science of medicine, civilization could never be effective in semi-civilized and barbarous lands.

The conquest of India by Great Britain has been maintained by superior military power; but its present tranquillity is largely due to the beneficent work of medical practice. Since the last great rebellion there, the English and missionary societies of our own country have established fifteen hundred hospitals and dispensaries, and medical schools are increasing in numbers. The light of Christian benevolence is now carried into the hitherto closed doors of the homes of the people. In China the same benign work has taken deep root. Fifty years ago Dr. Parker of the American Presbyterian Church, opened a hospital in Canton, and an immense work has been accomplished in surgical and midwifery practice, for which the Chinese had no remedies at all. Now a large number of hospitals and dispensaries have been planted along the sea coasts and throughout the interior. Besides male, a large number of well-educated female practitioners, are employed in them. It is the most touching spectacle of human sympathy and relief the world has ever known. Were it not for their skill in medicine the American missionaries would be expelled. Japan, Korea, Java and Africa, are being advanced in civilization in the same manner. Dr. Mungo Park and Dr. David Livingston were the most venturous explorers of Africa.

It is the belief of many physicians that if from the beginning of the settlements in this continent the medical office had been recognized as a Department of the State, on a parity with those of War, Justice and the rest, the great tribes of savage races could have been made friendly, and allies, and brought under the terms of a high civilization by the humane influence of our medical men.

Though Congress is voting vast sums for agricultural schools and experimental stations, yet these are above the reach of the great mass of farmers and their adult sons and daughters. They can not leave the fields and the household duties for at least nine months of the year, and they can not pay the expenses incident to college life; but schools of instruction, by means of lectures, demonstrations, drawings and experiments in physics, chemistry, and the structures and the functions of the chief organs of animals and plants, can be readily inculcated by the doctors in medicine who have themselves been taught in this manner. These lectures can be given by physicians during the winter seasons in the towns of the counties and within reach of the farmers' homes, and a central office, such as we propose, would aim to promote this without expense to the Government.

It will be the means of putting new life into the freshest and strongest minds of the people. Every farm would soon become an experimental station; Nature would be seen with new eyes, and the dull and monotonous lives of this most neglected class would become radiant with a new light. This may be counted one of the great influences that will follow the higher education of physicians.

The question may arise, whether such a Department in the Government would subserve the interests of any particular sect or school in medicine? We reply that, amid the apparent disparity in medical practice, there is one true unity and to attain this all true physicians are continually striving. It is evident that there can be but one anatomy, physiology, pathology, chemistry, physics or preventive medicine. The difference among doctors lies in therapeutics or treatment of disease, and as in the past, so for the future, practitioners will use a variety of remedies and in varying quantities, and there will be different modes of management of sick and injured people. With the advance in medical education the modes of treatment will become more unified.

The organism which is called medicine, like every other product of man's constructive genius, is striving to attain perfection, and to accomplish this it must be sustained in all its scientific undertakings by the co-operation of national and state legislation.

We ask each member of Congress who seeks relief for himself and his family in the times of their distress through the most accomplished practitioners of medicine, to consider that his mind is the type of that of millions who constitute the republic; and therefore we ask him to lend his influence to our effort to secure for the people the most highly trained persons in the science and art of medicine.

We hope that it is plain that a Secretary of Public Health would represent the medical consciousness of the nation, and that he would be one to whom we could all

look for the exploitation of measures that will direct continuous scientific collective research in regard to epidemic and endemic diseases, and especially those of a degenerative character; and thus make his department the repository of the most important measures that concern the welfare and comfort of the people; and his duties will steadily grow broader and stronger in adaptability to public needs.

Respectfully submitted on the part of the Committee.

C. G. COMEGYS, Chairman.

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## A Bill to Establish a Department of Public Health.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled.*

SECTION 1. That there shall be established a Department of Public Health. There shall be appointed by the President from the medical profession, by and with the advice and consent of the Senate, a Secretary of Public Health, who shall be entrusted with the management of the department herein established. He shall be paid an annual salary of $8,000.

There shall be appointed by the President, with the approval of the Senate, an Assistant Secretary of Public Health, at an annual salary of $5,000.

The Secretary of the Public Health shall, with the approval of the President, provide suitable offices for the department, and shall employ such assistants and clerks as may be necessary.

SEC. 2. It shall be the duty of the Secretary of Public Health to obtain through all accessible sources, including State boards of health, municipal authorities, and the Surgeon-Generals of the Army, Navy and Marine Hospital Service of the United States, weekly reports of the sanitary condition of all ports and places within their territories and departments, and he shall publish weekly abstracts of the information thus obtained and other pertinent matters received by his department. The said department also shall, as far as possible, by means of the voluntary cooperation of State and municipal authorities, of various general and special hospitals, sanitariums, public associations and private persons, procure and tabulate statistics of marriage, births (noting those that are illegitimate), and deaths from epidemic, endemic and all other diseases, specifying those of a degenerative character, such as malignant growths, and affections of the nervous, circulatory, respiratory, secretory, digestive and reproductive organs, and from violence, accidents, suicide, murder, and data concerning the fruit of consanguineous marriages and the transmissibility of insane, alcoholic, syphilitic, nervous and malignant types of constitution to offspring, and to evils of race miscegenation. He shall also procure information relating to climatic and other conditions beneficial to health, and especially in reference to the most favorable regions in the United States for the cure or relief of chronic diseases, particularly tubercular consumption. He shall also procure information as to the prevalence and ruinous effects upon the body and mind of intemperance and prostitution. He shall endeavor to ascertain the extent, the origin and classification of insanity in the several States and territories of the country. He shall investigate the state of comfort of the laboring classes in respect to their lodgment, their trades, occupations, the healthfulness of their workshops and the contents of the atmosphere they habitually breathe, and the prevalence of premature degeneration of the nervous and muscular systems by the exactions of piece-work employment. He shall obtain information in regard to the soundness of their food and purity of water-supply. He shall ascertain the ages at which the children of the poor are put to work, and its hindrance to their physicial development, and their lack of common-school education. He shall seek through the the State boards of health, information of the hygienic state of public school buildings respectiug their illumination, ventilation, and presence of noxious elements in the circumnambient air. He shall seek information in regard to the pollution of streams and navigable waters and public and private wells. He shall attempt, through the co-operation of the authorized medical schools in all the States, to promote the most extended and thorough training of students in order to fit them for the responsible duties that devolve upon practitioners of medicine. He shall, whenever an epidemic disease is spreading abroad, or in any country which by commercial or other relations may endanger

the health of the inhabitants of the United States, have power to call a conference of the Surgeon-Generals of the Army, Navy and Marine Hospital Service, and the executive officer or officers of the various State boards of health throughout the country, to consider and advise with him in regard to the best methods to be pursued to protect the country against the invasion of any such epidemic disease, and the results of such conference shall be, by the Secretary of Public Health, communicated to the President and his Cabinet, for such action as they may deem wise and expedient.

Besides the reports of the state of the public health which he shall make from time to time, the Secretary shall make an annual report to Congress, with such recommendations as he may deem important to the public welfare, and the report, if ordered printed by Congress, shall be done under the direction of the department. The necessary printing of the department shall be done at the Government printing office upon the requisition of the Secretary, in the same manner and subject to the same provisions as that of other printing for the several departments of the Government.

SEC. 3. The President is authorized, when requested by the Secretary of Public Health, and when the same can be done without prejudice to the public service, to detail officers from the several departments of the Government for temporary duty, to act under the department of Public Health to carry out the provisions of this act, and such officers shall receive no additional compensation except for actual and necessary expenses incurred in the performance of such duties. When a detail of such officers can not be made, the Secretary, approved by the President, may employ such experts, and for such time and in such manner as the funds at the disposal of the department may warrant.

SEC. 4. That to defray the expenses in carrying out the provisions of this act, the sum of fifty thousand dollars ($50,000) or as much thereof as may be necessary, is hereby appropriated to be disbursed with the approval of the President, under the Secretary of said department.

This act shall take effect sixty days after its passage, within which time the Secretary and Assistant-Secretary may be appointed.

OBLIGING.—Under ordinary conditions he was a man of prominence—but as he ascended the steps of his residence, very early in the morning, it was evident that he desired to be as much otherwise as possible. The cabby was lingering near to see that his charge was safely disposed of for the night. The door opened before the man on the steps could get his key to work, and he was met with the question:

"John where have you been?"

(*Silence*)

"John, where *have* you been?"

He turned to descend the steps.

"Are you going to answer my question?"

"Yesh, my dear, I am. From my pers'nal knowledge I can't give the desired inf'mation, 'n I'm goin' to ask the man that drives the hack."—*Life.*

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A FEW workingmen were discussing names of great scientists in Manchester. The name of Darwin cropped up. One of the company, less learned than the rest, said: "Darwen, I kna that place. A've been ther' monny a toime." "Get out, you fooil!" said another. "We're nut talking about the place called Darwen, but the mon. Hevn't ye nivver heerd o' Darwen? Why, if it hadn't been for Darwen we s'ould all hve been chatterin' monkeys, and nut gentlemen, like we are."—*Sheffield Telegraph.*

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EXPERIMENTS have been tried with a view to ascertain if color has an effect on certain forms of disease. In making this test a number of smallpox patients were placed in a room to which only red light was admitted. The patients were for the most part those suffering from unusually severe attacks, and about half of them being unvaccinated children. In spite of the violent form of the malady, they all made speedy and safe recoveries, with very little fever and but few scars.—*New York Ledger.*

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DOWN IN ARKANSAS.—"Well, Jim, how's the ague?" "Didn't I tell you about that? Why, I went into the old man Sharp's field one night about a week ago, and the old man got up and loaded his gun in the dark, 'n' cuss me if he didn't blow me full of two grain quinine pills! I hain't had an ache nor shake since."—*Life.*

# SOCIETY REPORTS.

## ORTHOPEDIC SECTION, COLLEGE OF PHYSICIANS OF PHILA.

*March 16th, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### APPARATUS FOR PREVENTING AND CORRECTING DEFORMITIES OCCURRING AFTER EXCISION OF THE KNEE-JOINT.

DR. G. G. DAVIS: In the treatment of resection of the knee, flexion often occurs. It is difficult to get firm union in a straight line, and I believe this difficulty is not recognized sufficiently, and efficient means are not taken to provide against it. This is seen not only in private practice, but still more frequently in cases on which operation has been previously done, which afterwards apply at our surgical dispensaries. I am quite of the opinion that effective apparatus of some sort is necessary. I do not know what appliances the other members have used for the treatment of this tendency, but the apparatus which I have found to be the most efficacious has been as follows:

It consists of two iron sides which are joined at the ankle and have a stirrup beneath the foot; on the inner side the upright reaches to the perineum; on the outer, to above the trochanter.

The outer piece is fastened above to a metal hip band passing three-fourths around the pelvis, and lying, like a truss, just below the crests of the ilia. The posterior portion of the leg is supported by the heel in the shoe below and a piece of sole-leather above going around the posterior half of the thigh, from one side-iron to the other and touching the gluteo-femoral fold. Pressure is made on the front of the knee by a padded sole-leather knee-cap fastened to the inside iron by two straps, while its outer side, passing down between the limb and side-iron, is depressed by one or two screws fastened to a plate on the outer side-iron.

Antero-posterior displacement is met by turning the screws and thus forcing the knee backward.

Lateral displacement is met by bending the side-irons in or out, as required, by wrenches.

Any tendency to inversion or eversion is met by twisting the outside iron; just below the hip-joint with wrenches.

A soft leather hip band will not do as it will not fix the brace firmly enough in relation to the pelvis, to prevent rotation. In order to avoid dropping of the toe, while the patient is going around with a high shoe and crutches, the ankle-joint should be fixed by locking it with a screw, which can be removed when the limb is used for walking.

I am averse to using any apparatus, like plaster-of-Paris, that cannot be altered, and conceals the part. I wish to see the limb every week so that if any tendency to deformity shows itself, it can be, at once, met by applying a positive pressure in the proper direction.

#### DISCUSSION.

DR. DEFOREST WILLARD: It seems to me questionable whether the plate upon the outer side will make as much pressure as the pad ordinarily placed in this position.

DR. G. G. DAVIS: It is simply a matter of taste. I prefer the screw arrangement because straps are apt to yield and become loose, while with it the parents can by turning the screw with a key, always keep the pressure firmly applied.

DR. DEFOREST WILLARD: I think a pad would prevent the joint from yielding outwardly and straps are more simple.

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DR. H. Augustus Wilson presented a

### CAST OF A LEG SHOWING RIGHTANGLE FLEXION AND ROTATION AFTER INCISION OF THE KNEE,

and said:

When I first saw this patient five weeks ago, at the Jefferson Hospital, he said he was fourteen years of age, and that nine years previously he was operated upon at St. Petersburg for what appeared to have been tubercular ostitis. The operation seems to to have been excision of the knee-joint, and it occurred to me it might be of interest to the Section to study the case, showing such serious ultimate deformity. For six months the child walked with crutches, but on abandoning them the leg became bent, and at the end of a year the leg presented the appearance of right-angle flexion.

At the time I performed secondary operation, at the line of the original incision there was an immense amount of callus. In sawing I also found a large amount of callus thrown in the popliteal space. The curve which existed was very large in the upper end of the tibia and flexion seems to have occurred in the callus; the case illustrating one of the unfortunate results of not using

absolute fixation and crutches long enough. From the history of the case I judge that the condition of tubercular ostitis existed something like two years previous to the first operation. It is interesting also to know that at the upper end of the tibia, which was the original seat of the tubercular ostitis, there was a clearly marked cavity, and in the center a fibrous mass of cheesy consistency. I gouged this out and the patient did fairly well until the relightening of the tubercular inflammation. There has been primary union and the inflammation has subsided under the use of iodoform injections. The case is interesting in connection with a number of cases which I reported at the Academy of Surgery, in which flexion took place after incision. (*American Journal of Medical Sciences*, March, 1893).

DISCUSSION.

DR. F. X. DERCUM: As displacement occurs from active flexion of the muscles, would it not be a good plan to excise the joint and then tenotomize the muscles:

DR. G. G. DAVIS: Tenotomy of the muscles would obviate the tendency to deformity occurring immediately after operation, but would have no influence upon deformity occurring subsequently; that is to say, three months, six months, or a year afterwards, because union would have already occurred.

DR. H. AUGUSTUS WILSON: In the paper which I read before the Academy of Surgery I discussed the same question put by Dr. Dercum, and it was the opinion of a number of surgeons that in excision of the knee, tenotomy of the ham-string tendon should also be done, I believe however, that the more rational explanation is that the weight of the leg causes it to drop and it thereby produces flexion. In excision of the knee, an inch is a small amount of bone to remove, and it naturally shortens the action of the ham string tendons. In any event, if posterior displacement takes place, we would expect atrophy, and flexion of the muscles would follow. I do not know if these views are correct, but they are largely advocated.

The explanation of many of these cases of after deformities lies in the condition of the bones themselves. The worst deformities I have found have followed tuberculosis where previously there had been local tissue removed. The real trouble lies in the fact that the supporting apparatus is dispensed with too early. The cases are prone to deformity because the point of union is not true callus; it is of softer nature. I am fully of the opinion of Dr. Willard as to the necessity of using manual force. If the surgeon grasps the limb above and below the joint, there will be little likelihood of breaking any bones.

I have, on two occasions, broken the femur to overcome deformities at the knee, but it was done purposely and in preference to performing osteotomy. Recently I have swathed the leg above and below the knee with steel rods so that all the force was applied to the knee. A steady application of force will very often lacerate the soft tissues and accomplish correction, whereas the sudden application of force is apt to break the leg at the point of the least resistance. There are many of these cases where there is slight flexion, and if it is impossible to get the limb absolutely straight, we must be content with such straightening as can be attained and repeat our efforts from time to time, usually with better functional results than could be obtained by any operative procedures.

DR. F. X. DERCUM: The question occurred to me whether, in cases of fracture occuring above the knee, a false joint ever ensues? And where does separation take place? Also I would like to ask if Koch lymph is at all used now?

DR. G. G. DAVIS: I would like to say a word about the use of the apparatus of Dr. Goldthwaithe which had been exhibited by Dr. Willard, because in it there is an attempt made to exert a force in a manner which has not yet been alluded to. Dr. Willard spoke of posterior luxation and said that in such cases he usually used excision. Ordinarily straightening of a joint is done by simple flexion and extension movements; not only can these movements be made with the apparatus shown to-night, but there is a direct pulling forward of the head of the tibia and fibula. If this apparatus will do that satisfactorily, it will obviate the necessity of resection in some of these cases of sub-luxation, and therefore I would like to hear the results of its trial.

DR. DEFOREST WILLARD: In regard to the employment of Koch's lymph, I have used it in a few cases during its popularity, but they did badly and suppuration quickly resulted; one knee I was obliged to excise and the patient died. I have not lost faith in its use for tuberculosis, but I think it was given to the profession before its properties were fully developed. Future generations will reap the benefit of what is now an experimental stage. It was launched on the world before it had been sufficiently tested and revulsion followed. Careful experimentation for five or ten years is yet necessary; therefore, while I have not lost faith in its ultimate results, I do not now employ it.

In regard to the fracture of the femur, I would say that I have never seen an injury from such fracture. It would be simply an osteotomy and not likely to give a false joint. In attempting to straighten by osteotomy, a knee which is at right angles, it would be possible not to have union strong enough for the transmission of force, and where I do not

get a perfectly straight limb by tenotomy and brisement force, I straighten it as far as possible and then let it rest for six, eight or ten weeks; then do osteotomy of the femur for correction of the remaining deformity. I do not excise under ten years, as I like to get as much growth as possible.

In regard to the question of excision I would say that it depends very largely upon the age of the patient. In young cases I advocate conservatism; in adults I employ more radical measures. As to the deformities which occur after excision, I think that nine cases out of ten are those which arise from too early use of the limb. Five per cent. of the cases relapse even though good union is obtained. I saw to-day a case which I sent home on crutches over a year ago. She returned all the better for the enforced rest, and there is not the slightest evidence of deformity. When I operate upon a joint I keep it at rest and protect it by an apparatus just as long as I feel any doubt as to its full recovery—six months, a year, two years after I feel it to be perfectly solid. I use an apparatus somewhat similar to the one described by Dr. Davis to-night, and its prolonged use is advisable.

As to the question raised by Dr. Dercum, I would say that in severe cases where the limb cannot be brought into a perfectly straight position, tenotomy is desirable. In all cases of deformity following knee-joint disease, it is a matter for consideration whether excision or forcible straightening shall be done. In my experience it is frequently better to forcibly straighten than to perform excision, especially if the subject be young. Within the last few years I have employed open incision of the semi-membranosis and the semi-tendenosis and biceps tendons, and have then applied powerful force, even to an extreme degree, and I have never had rupture of the popliteal artery or veins; have never broken an epiphysis or fractured a femur. Should fracture result, it would make little difference; it is the same as an osteotomy. I do not, of course, under take to forcibly straighten a knee where there is a large amount of tubercular deposit. In children it is a serious matter to excise a knee-joint, for when there is flexion to the amount of a right angle there will result a large amount of shortening.

The amount of force which can be applied by the hands without injury is very great. This winter I have straightened many limbs, which two years ago I should have treated by excision, and they are all doing well. I am thoroughly in favor of the absolute rest which is gained after an operation by the application of plaster cast. The muscles recognize the absolute fixation and as nothing is required of them, they rest accordingly.

I am of opinion that manual pressure is the best. I have here, however, an apparatus made by Dr. Goldthwaithe, of Boston, for the forcible straigthening of knees, especially where there is posterior displacement. I have never used it as I received it only last night. Since I have investigated its possibilities, however, I believe I shall still continue to use my hands. The leverage is most powerful and in strong hands, I should fear serious injury from its use. In adults it is a difficult matter to exert sufficient force and Dr. Goldthwaithe gives a number of cases in which he has been successful with the use of this instrument.

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*A Text Book of the Diseases of Women*, by Henry J. Garrigues, A. M., M. D., Professor of Obstetrics in the New York Post-Graduate Medical School and Hospital; Gynecologist to the German Dispensary in the City of New York; Consulting Obstetric Surgeon to the New York Maternity Hospital; Consulting Obstetrician to the New York Infant Asylum (resigned); ex-President of the German Medical Society, of the City of New York; Fellow of the American Gynecological Society; Fellow of the New York Academy of Medicine, etc. Containing three hundred and ten engravings and colored plates. Philadelphia: W. B. Saunders, 1894.

The author says in his preface that the work is for busy doctors and undergraduates, and that it is his intention to make it a book of quick reference for those who have not time for more elaborate reading, studying or hospital experience.

He forgot, however, in some of his chapters, the fact that many of his operations and procedures are fraught with imminent danger to those upon whom they are performed, and yet he raises no hand of warning, or caution to those who without training or experience may turn to his pages for information.

The chapter embracing electricity, for instance, is one that may cause some enthusiastic, but inexperienced man to do far more damage than he will be likely to do good. Electricity in gynecology by experts is considered questionable by many, and in the hands of the general practioner and student, may do more mischief than can easily be repaired. Still in this volume there is much to be commended.

To one accustomed to gynecological work, the book will be valuable as giving many hints and suggestions—the various modes of

operating by different authors, and in many cases his own views and opinions, based on personal experience, which are sound, and up to the high water mark of the latest and most improved method of the best operators.

Another objection to the work is the failure of the author to give his own views and reasons on all subjects treated. For, wherever he has done so, there is proof of the soundest professional judgment and skill in his methods. Notwithstanding these defects, the book is one of the best now before the profession of the character aimed at by the author. It is well gotten up—the style easy and engaging. The illustrations are accurate and fully demonstrative of the ideas intended to be conveyed, and altogether it is a work that will find a welcome in the library of every physician who reads and studies the works of our best and most progressive men.

G. R. D.

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*Lectures on Auto-Intoxication in Disease, or Self-Poisoning of the Individual.* By Ch. Bouchard, Professor of Pathology and Therapeutics, Member of the Academy of Medicine, and Physician to the Hospitals, Paris. Translated, with a preface, by Thomas Oliver, M. A., M. D., F. R. C. P., Professor of Physiology, University of Durham; Physician to the Royal Infirmary, Newcastle-upon-Tyne; and Examiner in Physiology, Conjoint Board of England. In one octavo volume; 302 pages. Extra cloth, $1.75 net. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry street.

Saliva, bile, peptones, alkaloids of digestion and of intestinal putrefaction from normally present bacteria are constantly menacing the organism. Most of these poisons are destroyed by the liver. The antitoxic action of the liver is shown by trituration of an otherwise fatal dose of nicotine with fresh liver and injection of the filtrate into an animal which manifests few serious symptoms. Trituration with muscular tissue has no such protective result.

The author has little faith in the vicarious action of the skin and intestine in renal insufficiency since the perspiration and intestinal juice remove only thirty centigrams of urea per liter, the proportion present in the blood plasma.

The author shows experimentally that fresh, healthy urine is toxic, but no one of its ingredients gives correspondingly toxic results. Urea is fatal only when ten times as much has been injected into the circulation as is found usually in the blood of persons dead of "uræmia."

Bouchard's treatment of typhoid is as follows: (*a*) fifteen grams of magnesium sulphate every three days; (*b*) for four consecutive days, twenty hourly doses of two centigrams of calomel (as antiseptic); (*c*) fifteen c. c. (tablespoonful) every two hours of the following nutrient and antiseptic paste—vegetable charcoal, 100 grams; iodoform, one gram; naphthalin, five grams; peptone, fifty grams; glycerin, two hundred grams; (*d*) injection morning and evening of 500 c. c. of a 1 per mille solution of carbolic acid; (*e*) eight baths daily, the water being originally 2° C. (3.6° F.) below the body temperature, and reduced about 1° F. in five minutes, never below 86° F. The cooling process requires an hour or more. If the temperature is high, large doses of quinine are given every three days; (*f*) a diet of broth with barley, lemonade and the paste already mentioned. Bouchard's mortality rate has been reduced from 25 per cent. to 7 per cent. by this method.

The author emphasizes in detail the importance of stimulating the emunctories and refers to bleeding as a rapid means of elimination of toxines in anuria.

No review can do justice to this work. It is matter for slow reading and assimilation. There is almost no waste of words nor literary padding. In a sense, one is disappointed with the book, as with every other book which contains instead of brilliant generalizations, the results of carefully proven investigations.

A. L. B.

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*Congenital Affections of the Heart,* by George Carpenter, M. D., Lond. Published by John Bale & Sons, London, W., 1894.

This little brochure of 102 pages gives a very excellent resume of the congenital affections of the heart, and well repays careful reading. The author points out clearly the occurrence of endocarditis rheumatica prior to the age of four months, and refers in an interesting manner to the difficulties of diagnosis at this early age. The various abnormalities of the valves are arranged in tabular form on page 46. In 181 cases of various congenital cardiac affections collected by Peacock, 119 showed malformation of the pulmonary orifice and the cornus arteriosis.

Reference is made to the infrequency of malformations of the arteries, and that the aorta occasionally forms a double tube surrounding the trachea, and that coronary arteries may originate high up in the aortic arch, or be given off by some one of the vessels. In somewhat similar manner two ascending or two descending venæ cavæ are occasionally met with.

The chapter on malformations of the heart is interesting, and, in addition to the transposition of the heart and viscera, reference is made to cases where the heart is situated wholly or in part external to the thorax, or in association with protruded abdominal viscera, and one case is recorded where the heart was found situated near the right kidney.

That these cases also occur in animals is shown by an autopsy made by Professor Harger upon a cow, which had been under observation at the Veterinary Department of the University of Pennsylvania for more than a year. The heart was in the neck, where it had been palpated and auscultated during life.

This book, though small, is full of information, and the twenty-two cases reported are of special value.

J. D.

*Clinical Lectures on Pediatrics.* Delivered in the Vanderbilt Clinic during the session of 1892-93, by A. Jacobi, M. D., Clinical Professor of the Diseases of Children in the College of Physicians and Surgeons of New York, etc., etc. Baily and Fairchild, 1893.

This modest little volume has found its way to my table, and also to my understanding. It is unpretentious in its salutatory, and unambitious in its design, but nevertheless it is far more than the author claims for it. If its pages are opened even when one is tired and sleepy, interest will soon be awakened and the book is sure to be closed reluctantly.

The subjects treated of are such as come to the doctor from day to day, and the clear and well-defined manner in which the author goes into each case as it comes before him is refreshing and engaging, and withal, eminently instructive.

To the busy doctor who has time only to cull a little here and there—I will say he can find here, within the pages of this little volume, more than in many far more pretentious in their make-up. I welcome it to my table and shall often enjoy its perusal.

G. R. D.

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*The discovery of Modern Anæsthesia. By whom was it made?* A brief statement of facts by Dr. Laird W. Nevins. Published by Geo. W. Nevins, Cooper Institute, New York, 1894.

The most important and valuable discovery of the present century is that of anæsthesia.

There are four claimants for the honor of this discovery. For many years our leading surgical and dental journals were filled with exciting and bitter discussions as to whom the honor belonged; each advocating the claims of this or that individual; and this discussion is now being revived by many of our professional journals.

Dr. L. W. Nevins has written a small volume on the subject, in which he does not advocate the claims of any one of the four individuals named, but has gathered all the facts possible on the subject, and, with an even hand has balanced and weighed the degree of merit belonging to each. He has, in an interesting way, presented the only free, impartial and unbiased statement on the subject which I have ever seen.

The book contains fine portraits of the four claimants named, with a biographical sketch of each, and engravings of the monuments erected to their memory; also a likeness of the two dentists who were incidentally connected with the discovery claimed for Dr. Wells; and a fine portrait of Sir James Y. Simpson, who discovered the anæsthetic powers of chloroform.

All these portraits, together with an enlarged engraving of the Ether Monument in the Public Garden at Boston, have been attractively arranged and produced on a large heavy sheet of paper, 19x24 inches, intended for framing.

The book and the picture should go together; one for the office-wall, the other for the office-table or library. Considering the insignificant price ($1.50) no physician of note can afford to be without them.

G. Q. C.

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# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

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THE AMERICAN JOURNAL OF OBSTETRICS for April. Dr. Charles P. Noble contributes a paper on

**Acute Puerperal Cellulitis and True Pelvic Abscess.**

He reports several cases as demonstrating the following:

1. That in the puerperal state pelvic cellulitis and true pelvic abscess occur as the result of septic inflammation.

2. That inflammation may spread from the vagina or uterus along the pelvic lymphatics to the broad ligaments without involving the Fallopian tubes.

3. That peritonitis can be set up by the spread of inflammation from the broad ligaments to the peritoneum without involvement of the Fallopian tubes.

4. That very extensive pelvic exudate and intra-peritoneal adhesions can be absorbed.

The author believes that pelvic cellulitis and true pelvic abscess are comparatively rare conditions, and that the usual variety of pelvic inflammation is a salpingo-peritonitis. He has not met with the pelvic cellulitis except in the puerperal state, and believes that it does not occur except as a result of infected wounds of the vagina and perineum.

**The Aseptic Dressing of the Umbilical Stump**

is the title of a paper by Dr. Joseph Eve Allen. In it the author urges the application of the principles of aseptic surgery to the care of the umbilical cord, reviewing the opinions of various authors as to the dangers of infection. He declares that the process of separation of the cord is one of dessication and not one of suppuration and ulceration. Whenever, therefore, putrefaction, or ulceration appears it is proof positive that the dressing has not been aseptic. The writer's method is to secure the cord temporarily by means of a clamp or ligature till after the child is washed. After this the attendant should make his hands perfectly aseptic by repeated washings with soap and water, and scrubbing with a nail brush, and then finishing with a 1:1000 bichloride solution. The funis and abdomen of the child should be wiped off also with this bichloride solution.

The cord is again cut about an inch and a half from the abdomen and the gelatinous

material pressed out. The bichloride solution must then be again used freely, after which the funis is tied with an elastic silk ligature which has been sterilized by first boiling for half an hour in a 1: 500 bichloride solution and then immersing in a solution of iodoform in sulphuric ether 1: 50. These ligatures after having thus been prepared, should be cut into lengths of about four inches and kept dry in a clean wide-mouthed jar till used. The cut end of the cord should be touched with a bichloride tablet.

The cord is then enveloped in a piece of sterilized gauze, not sublimated, which has previously been saturated with glycerine. Another pad of sterilized gauze saturated with glycerine is then placed over it and the whole held in place by a sterilized flannel bandage. The gauze used in the dressings should not be sublimated on account of the eczema produced by long contact of corrosive sublimate with the skin. Chemically pure glycerine is especially indicated as an application to the umbilical stump, for the reason that it is bland, unirritating and antiseptic, and has great hydroscopic properties, thus hastening the process of desiccation. Cords treated in this way often fall within three days.

In regard to the after-treatment, until the funis separates the bandage should be opened twice daily and the dressings saturated with glycerine. The top pad should be removed daily and replaced by a fresh piece of sterilized gauze. Whenever soiled the flannel bandage should be changed. After the cord falls the umbilical fossa must be filled with aristol, a dry pad of gauze placed over it, and the bandage reapplied. Repeated microscopic examinations of the debris of cords that were treated as above failed to show the presence of any form of microbe.

When the umbilicus ulcerates or becomes infected, the best treatment to be pursued is repeated irrigations with peroxide of hydrogen or a 1: 500 bichloride solution, after which the stick nitrate of silver is to be thoroughly applied, the parts thickly dusted with aristol and covered with a sterilized gauze pad and flannel bandage.

Aseptic precautions should be observed at all times, but especially during the prevalence of epidemics of zymotic diseases, and when the infant is exposed to a contaminated atmosphere such as exists in crowded tenements and hospital wards.

Dr. T. Ridgway Barker describes

**An Ideal Napkin for the Puerperal Woman.**

The napkin is made from cheese cloth and cotton, both baked so as to be rendered sterile. A square is cut from the cheese cloth, nine by nine inches, folded over, making it four and a half inches wide; a piece of absorbent cotton is cut just the same size (four and a half by nine inches), and placed between the folds of the cheese cloth. In this manner is prepared in the simplest possible way a compress which is readily applied and needs nothing to hold it in its place, so closely does it adhere to the skin when the parturent occupies the semi-recumbent position Before applying a fresh dressing the external genitalia and the mouth of the vagina should be bathed with warm water. The patient is given four warm vaginal douches, by means of a fountain syringe, a day during the first week, and thereafter two a day. These serve a useful purpose in keeping up drainage. Should any odor be noticable the compresses may be dusted with powdered boric acid. The addition of a drachm or more of compound spirit of lavender to the water for bathing adds materially to the comfort of the patient.

Dr. T. J. Crofford contributes a paper entitled

**My Experience with Tubercular Peritonitis.**

The author reports a number of operations for the relief of the disease, as the result of which he comes to the following conclusions:

1. Tubercular peritonitis is an operable disease.
2. The immediate danger from the operation is not materially influenced by the character of the inflammation.
3. An early operation is of the greatest value.
4. The chronic or slowly progressing variety offers the best indications for surgical interference.
5. When the primary desposit is in the tubes, an early salpingotomy will cure the disease.
6. Operations later in the disease will frequently prolong life and possibly cure.

Dr. J. T. Binkley discusses,

**The Relations between Salpingitis and Appendicitis Vermiformis,**

reporting a number of cases where abdominal section was performed for tubal and ovarian disease and in which the appendix was found involved. The author divides these cases into two classes: First, those in which the appendix is infected directly or indirectly by the tube; and second, those in which the appendix plants the infection in the tube. In the first class we have the enlarged and inflamed tube presenting an attractive surface to which the wandering appendix may become attacked. As the result of this attachment there may occur a direct infection of the appendix by the transmission of microbes directly through the walls of the tube and the appendix, or the appendix may become infected indirectly by being bent upon itself, or by having exudations thrown about it, causing constricting bands. These bands and bends produce obstruction, and the obstruction causes foreign particles to be retained, and salpingitis naturally results.

The lessons to be learned are: First, that greater care must be exercised in freeing the uterine appendages from adhesions on the right side that on the left; second, that all detached tissue on the right side should be carefully examined with the expectation of finding an adherent appendix, which, if found, should be removed. He strongly advises its removal in every instance where it has once been adherent, because of its tendency to become adherent to various points on the peritoneum.

The author suggests that this body may be responsible for a large percentage of the colic

and reflected pains that follow laparotomies.

The author believes that the chief cause of the downward position of the appendix in women is the shape of the pelvis, which is broad and flaring, and does not have the forward ridge or angle of the pelvic brim under the head of the colon which is found in men. The other factors also favor this position of the appendix: first, the corset, which tends to force it down; and, second, childbirth, which relaxes peritoneal attachments.

Dr. Edward E. Morse discusses, "The Use of Certain Antiseptics in Midwifery," advocating the use of creolin and lysol as being free from poisonous and irritating qualities, and at the same time possessing efficient germicidal properties. He advises the use of a 1: 500 solution of the bichloride of mercury for the hands, followed by their immersion in creolin or lysol solution. By this arrangement the maternal soft parts are quite protected from contact with the corrosive, and the danger arising from such use avoided.

Dr. F. Byron Robinson describes

**A New Method of Treatment of Uterine Myoma without Removal of the Uterus,"**

by litigation of the ovarian and uterine arteries. The author describes a case in which, through an abdominal opening, he ligated the ovarian artery and then applied two ligatures to each uterine artery for about two-thirds of the distance from the tube to the internal os. He did not remove the ovaries and tubes. The patient made a good recovery; an abdominal fistula remained for several weeks.

Three months after the operation the uterus was about two-thirds its former size, and three months later it was one-half its original size. For the past six months the atrophy has been continuous. The patient has had slight hemorrhages but considers herself well. The author has performed the operation three times, and so far with good results. Great care and judgment must be exercised, in the cutting off of the blood supply of the uterus, not to go beyond the limit of safety as regards gangrene. The minimum amount of blood supply necessary for the life of the uterus cannot be stated, but the author has demonstrated that the ovarian artery and the uterine artery for two-thirds of the distance from the tube to the internal os can be safely ligated.

Dr. George J. Lochboehler presents the report of "A Case of Prolonged Prolapsus Funis in Twin Pregnancy." The first child was born alive after the funis had been prolapsed for two hours and a quarter. The second child was born alive a few minutes later. The author believes that this is the greatest length of time for a living child to be born when the cord has been prolapsed.

The remaining papers in this issue are: "Note on Oligohydamnion" by Dr. W. W. Jaggard. There was absolutely no liquor amnii the child being surrounded by a tough membrane and covered with a thick layer of vernix caseosa and a thick, viscid, gelatinous substance. The child was deformed and lived only an hour. The paper is illustrated with photographs of the child.

"Urethral Caruncle" by Dr. Edward Nicholas Liell.

THE MEDICAL CHRONICLE,

of Manchester, Eng., for March. Roger Williams, F. R. C. S., continues his paper on

**Sarcoma of the Breast.**

Pure Sarcomata, he says, seldom originate such large tumors as the adenoid variety though the main features of the disease are very similar to those met with in the latter variety.

In regard to the so-called alveolar variety he state that recent investigation have shown that these growths arise from the endothelial cells of the adventitia of the lymph spaces. If we accept this view of their origin, they should be classed with the cancers, for embryological researches have shown, that the endothelium is a derivative of the archiblast and not of the parablast, to which its origin has hitherto generally been ascribed. There are many facts in the morphology and clinical history of the disease that are best explained from this standpoint. In as much as these growths are highly malignant, they should be freely extirpated, as soon as possible, together with the breast and overlying skin; and the axilla should be cleared as well in every case.

Any form of melanatic neoplasia of the breast is of extreme rarity. The author's table of 2,397 consecutive primary neoplasms of the female breast does not contain a single instance. It appears, however, to be rather less exceptional in the male breast, for of 100 primary cancers of this part collected by the author three were of the melanotic variety.

Myxoma is a rare form of mammary neoplasm, since of 2,397 female cases there were only two examples of it.

In their main features myxomata of the breast closely resemble sarcomata, of which they are evidently but a sub-variety. The chief pathalogical consequence of the histological diversity subsisting between, these two forms of the disease is that the myxomata rarely originate metastases, and that they recur locally after removal much less frequently than the sarcomata. Mammary myxomata acquire to be treated in accordance with the same principles as mammary sarcomata. The prognosis is, however, more favorable, statistics showing that local recurrences after removal are met with only in 16.6 per cent. of all cases.

The author divides Keloid into two varieties: (1) the commonest form, in which the disease usually presents as an oblong, flattened outgrowth from the derma, of smooth, purplish-red aspect, much resembling an over grown irritated scar. When the question of treatment is under consideration, it is well to remember that, having attained a certain size, the disease often ceases to increase. Moreover, under the influence of soothing applications, it sometimes manifests a tendency to spontaneous resolution. Consequently, operative interference, caustic and irritant applications should be sedulously avoided. The best treatment is to cover up the lesion with belladonna, salicylic acid, or ammoniacum cum hydrargyro plaster.

(2) The rare form of the disease is characterized by the formation in the derma of whitish, ivory-like, slightly elevated, indurated areas.

which feel firm and elastic, each being surrounded by a faint, lilac-colored vascular areola. It seems in reality to be a localized scleroderma. If left alone, it generally progresses, but very slowly; and after a time retrogressive changes sometimes supervene spontaneously.

In regard to sarcoma of the male breast, the author states that it may be inferred that all the varieties met with in the female breast may also be found in it, although, of course, such occurrences are of great variety. Most of the recorded cases known to him have been pure sarcomata. In 2,432 cases of primary breast neoplasms analysed by him 99 of which were sarcomatous, there were 2 instances of myxoma of the male breast. A case of mammary adeno-myxoma in a man has been recorded by Obolensky.

Appended to the paper are reports of cases of the various forms of sarcomata described.

In the "Clinic" department, R. T. Williamson, M. D. describes "The Early Pathological changes in Disseminated Sclerosis," reporting a case. The paper is illustrated with wood cuts of sections of softened patches in the grey matter of the cord, and sections of blood vessels.

R. T. Williamson, M. D., reports "A Case of Cerebral Abscess secondary to Pulmonary Disease."

Robert E. Lord, M. D., reports "Two cases Illustrating the Difficulties in the Diagnosis Ulcer." Dr. Lloyd Roberts, M. D. continues his paper entitled, "Further Cases of Ovarian Cystic Tumors" reporting a number of cases.

## NEWS AND MISCELLANY.

### Pennsylvania State Medical Society.

The following is a list of the addresses and papers which have been appointed to be read or have been secured by the Committee on Scientific business for the meeting of the Pennsylvania State Medical Society, to be held in Philadelphia, May 15 to 18, inclusive.

*Annual Addresses.* Medicine, W. S. Foster, Pittsburg; Surgery, G. D. Nutt, Williamsport; Obstetrics, E. E. Montgomery, Philadelphia; Mental Disorders, T. M. T. McKennan, Pittsburg; Hygiene, J. H. Wilson, Beaver; Ophthalmology, Geo. E. de Schweinitz, Philadelphia.

*Medical Papers.* Charles W. Dulles, Hydrophobia; H. F. Slifer, Dietetics; John M. Batten, Unique Cases in Practice; W. C. Hollopeter, Therapeutics of Whooping Cough; William P. Munn, (Denver, Col.,) Colorado Climate for Consumptives; R. G. Curtin, Subcutaneous Emphysema; John Aulde, Diarrhœal Diseases; Wharton Sinkler, Acroparæsthesia; Adolph Koenig, Typhoid Fever; W. E. Hughes, Tapping of Abdominal Effusions as a Therapeutic Measure.

*Surgical.* E. Laplace, Radical Cure for Hernia; F. LeMoyne, Modification of Pirogoff's Amputation; X. O. Werder, Surgery of Gall-bladder; T. S. K. Morton, Section of Tendo Achillis in Fractures and Dislocations; John B. Deaver, Appendicitis; G. G. Davis, Amputation near the ankle; O. Horwitz, Stricture of the Urethra; Charles W. Dulles, Treatment of Fractures at the lower end of the Humerus; J. M. Barton, Acute Intestinal Obstruction; Edward Martin, Ocular Exploration of the Bladder and Urethra; John B. Roberts, Thyroidectomy.

*Obstetrical and Gynecological.* J. C. McAllister, Puerperal Eclampsia; Charles P. Noble, Uterine Fibroids; J. M. Baldy, Acute Endometritis; Anna M. Fullerton, Studies in Obstetrics and Gynecology: Horace Fox, Symphyseotomy and other Procedures; B. F. Baer, Cholecystoenterostomy.

*Eye and Ear.* S. L. Ziegler, Corneal Ulcers; S. Mac Cuen Smith, Diseases of the Ear; H. F. Hansell, Surgical Treatment of Internal Strabismus; Charles H. Thomas, Eye Strain; Charles Burnett, Tympanic Vertigo; Louis F. Lautenbach, Massage Methods in the Relief of Tinnitus; L. Webster Fox, Capsulotomy after removal of Cataract.

*Nose and Throat.* W. H. Daly, Intranasal Surgery; William R. Hoch, Nasopharyngeal Catarrh.

*Skin.* J. V. Shoemaker, Clinical Observations; M. B. Hartzell, Epithelioma of the Skin.

*Tuberculosis.* Arrangements have been made for a discussion on Medical and Surgical Tuberculosis, and papers will be read on Medical Tuberculosis as follows: S. S. Cohen, Curability and Treatment; J. M. Taylor, Physical Phases; A. M. Cooper, Contagiousness; L. F. Flick, Prophylaxis; Hugh Hamilton, Medical Tuberculosis; T. J. Mays, Strychnine Treatment of Pulmonary Consumption; D. Longaker, Case of Tubercular Meningitis.

The following members of the Society have announced their wish to take part in the discussion on Medical Tuberculosis: J. H. Musser, W. B. Ulrich, J. C. Wilson, J. S. Cohen, W. E. Hughes.

The following papers on Surgical Tuberculosis will be read:—C. B. Penrose, Tuberculosis of the Fallopian Tubes; H. A. Wilson, Treatment of Tubercular Caries of the Spine; E. B. Haworth, Case of Tuberculosis of the Knee-joint.

The following members will take part in the discussion of Surgical Tuberculosis:—J. B. Roberts, De F. Willard, G. G. Davis, J. K. Young, J. M. Barton, B. F. Baer.

Tubercular Manifestations of the Skin will be discussed by H. W. Stelwagon.

Besides these, the following papers on general subjects are announced:—Hildegarde H. Longsdorff, Christian Science and the Medical Profession; S. S. Cohen, Should the Journal of the American Medical Association be used to Promote Quackery; E. Jackson, Reasons for the Revision of the Code of Ethics; O. H. Allis, Cramming in Medical Schools.

The Committee has obtained the consent of Dr. Benjamin Sharp, of the Academy of Natural Sciences, to exhibit to the Society his beautiful series of lantern pictures of the Leper Settlement at Molokai, Sandwich Islands, and of lepers in various stages of the disease.

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## ORIGINAL ARTICLES.

### THE EXTINCTION OF TUBERCULOSIS.*

GEORGE H. ROHE, M. D.†

This Ninety-Sixth Annual Convention of this Faculty should be to us an occasion of congratulation. During the past year, our losses in membership have been few, and our gains not inconsiderable.

The semi annual meeting held in Annapolis last November was very successful, in point of attendance as well as in the character of the work accomplished.

In an address at the opening of that meeting, I said: "A legitimate object of organization is to use it as a power to secure legislation. Not legislation for our benefit as physicians, but legislation for the public good. The medical profession wants nothing for itself from the Legislature. The legislation in which the profession is interested is such as will be for the benefit of the whole people. Public health laws, medical registration laws, lunacy laws, were all intended for the good of the public, although always originated, and their enactment promoted by, the efforts of physicians.

It gives me especial gratification to call your attention to some recent results of such organization in this State. During the last session of the General Assembly three measures were considered in which the medical profession were interested, and which had their origin in committees appointed by this Faculty. These measures were: The Amendment of the Medical Practice Act, the bill for an Additional Hospital for the Insane, and the Act for the Prevention of Blindness in Infants. Each of them passed in essentially the shape in which it was recommended by the Faculty through its appropriate committees. Having watched the progress of these measures through the Legislature, I believe I may say that not one of them would have passed in satisfactory form if the members of the Legislature had not been impressed by the fact that the organized profession of the State, as represented in this Faculty, endorsed and supported them. In this connection I may be permitted to mention a circumstance which, I think, justifies this statement. When the bill for the prevention of blindness was put upon its passage in the House of Delagates there was a good deal of opposition to some of its provisions. The bill was eloquently and intelligently defended by the Baltimore City delegation and the Committee on Hygiene, but the opposition was so determined that for a time its success was problematical. It was not uninteresting to note that the only effective opposition came from those counties which are still unrepresented in this Faculty.

There is additional reason for congratulation in the fact that all the labor of getting a law passed through the Legislature was not rendered nugatory by unfavorable executive action, as has happened to

*The President's Address before the Medical and Chirurgical Faculty of Maryland, April 24, 1894.

†President of the Medical and Chirurgical Faculty of Maryland; of the American Association of Obstetricians and Gynecologists; Professor of Therapeutics, Hygiene and Mental Diseases in the College of Physicians and Surgeons of Baltimore: Superintendent of the Maryland Hospital for the Insane, Catonsville, Md.

the profession of this State heretofore. Having at present in the executive chair a Governor "noted for his common sense," as was happily said by Dr. Preston, in the discussion on the Care of the Insane at Annapolis, all our bills have been approved and are now laws.

These successes should only render more forcible the appeal of the Committee on Membership for a larger representation of the profession of the State in the Faculty. There is room in this organization for every honorable regular practitioner in Maryland.

I will now invite your attention to some considerations showing the possibility of

THE EXTINCTION OF TUBERCULOSIS.

For over two thousand years a portion of the medical profession has believed in the contagiousness of consumption. A not in considerable proportion of the laity has likewise leaned to this view. So strong was this belief at one time that toward the close of the eighteenth century a law was promulgated in the kingdom of Naples, making very stringent regulations looking to the registration of consumptives, the segregation of the sick in hospitals and the destruction of infected articles. It seems that at the beginning of the present century the prevalence of consumption in Southern Italy was so great that the expression, "See Naples and die," could almost be taken in its literal sense.

About thirty years ago Villemin demonstrated the communicability of tuberculosis by a series of experimental inoculations upon animals. The results obtained by this investigator were soon confirmed by Chauveau and others. It was, however, not until the epoch-making discovery of the tubercle bacillus by Robert Koch, in 1882, that the value of the researches of the two distinguished French experimenters was generally recognized. Since that time the view that tuberculosis is an infectious and communicable disease has gradually pervaded the profession until to-day there are probably few physicians laying claim to common sense and current knowledge who would attempt to controvert it.

Coincidently with the general acceptance of the infectious nature of tuberculosis have come experiments to more definitely indicate the common methods of infection, and endeavors to restrict the disease within narrower limits. That this is a laudable striving must be conceded when we reflect that the annual mortality from tuberculosis in its various forms in the United States is 163,500, or nearly 450 per day; and that in this city the deaths from consumption of the lungs alone reach nearly twelve hundred per year, a ratio of 13.69 per cent. to the total mortality. If the deaths from tuberculosis in its various forms were included, the ratio would amount to over fourteen per cent., or one in seven, which is the ratio throughout the world, as stated by Koch in his memorable paper announcing the discovery of the *bacillus tuberculosis*.

In accepting the infectious nature of this disease, we must not overlook the influence of the receptive condition of the individual in determining the time or place of infection. While the value of hereditary predisposition in determining phthisis is often over-estimated, we cannot ignore it altogether; neither may we undervalue the effect of an acute or chronic inflammation, a traumatism, or other weakening factor in rendering the tissues less resistent, or more receptive to the infective agent. These and many other conditions governing the infection of the individual must be recognized and accorded their full worth. The essential fact remains, however, that without the inoculation of the bacillus tuberculosis we cannot have consumption, or any form of tubercular disease; and if by any means we can exclude this infective agent from the body the individual is safe from the disease.

There are two principal channels of infection in tuberculosis; one is by the digestive tract and the other, far the more important, by the respiratory organs.

Children are especially liable to infection by way of the digestive organs. An infant nursed by a consumptive mother, or one fed on milk from tuberculous cows, may become tuberculous if the food contains the infective agent. It has been shown that the milk may contain tubercle bacilli, even though there is no recognizable local tubercular disease of the lacteal glands. It is highly probable that the frequency of tuberculosis of the intestinal canal, the peritoneum, the mesenteric glands and other abdominal organs in the young, is in most cases attributable to direct infection by tuberculous milk. In the adult this avenue of infection is likewise open. Meat from tuberculous ani-

mals, or other articles of food accidently contaminated by the tubercle bacillus, may be the medium of communication. Secondary infection, from swallowing the bacillus-laden sputum from the lungs, is also not infrequent.

I need hardly say, however, that in the great majority of cases of tuberculosis the infection takes place by way of the respiratory organs, which also become the principal, and generally the only, seat of the disease.

It is held by some, and I am inclined to consider the belief well founded, that the tubercle bacillus cannot effect a lodgment in the tissues and begin its destructive action, unless these are weakened in their resistive power by an inherited defective organization, or by acquired conditions of lowered vitality. It is a result of clinical observation that a catarrhal pneumonia, for example, is often a forerunner of pulmonary consumption. It is assumed, with good reason, that the anatomical elements of the lining membranes of the inflamed air-cells and finer bronchial tubes succumb to the attacks of the invading germ, carried in the inspired air, while in a state of health the tissues could resist the destroying organism. This simply emphasizes the importance of avoiding any factors tending to depress the vital condition of the organism or any of its parts.

The tubercle bacillus does not multiply under ordinary conditions outside of the body, and the fully developed organism when removed from the conditions favoring its growth in the body soon loses its vitality. But the spores of the bacillus, or the germs of the germ, as one may say, are extremely resistant and retain their power of growth and development for a considerable period. The dried spores are thus always potential sources of mischief if accidently taken into the system by inhalation or swallowing. They may also be inoculated in wounds or traumatisms, but this mode of infection is comparatively rare, and may be left out of account in the present discussion.

Careful investigations by Baer and Cornet have shown that the death-rate from consumption is four times as great in German prisons as among the free population of the same age. In convents, asylums, and similar institutions, tubercular diseases are also extremely prevalent. In the Maryland Hospital for the Insane, over thirty per cent. of the deaths are due to tuberculosis. I am confident that within the last two years at least three patients contracted the disease by infection in the wards. Efforts have been made recently to minimize this danger.

Dr. Lawrence F. Flick has shown by a patient and laborious study of the cause of death in the fifth ward in the City of Philadelphia, that certain houses in that ward are infected. He found that for a period of twenty-five years, from 1863 to 1887, all the deaths from tuberculosis in the ward occurred in less than one-third of the houses, while in 1888 over one-half of the tubercular deaths occurred in these same houses, demonstrating beyond a doubt that these houses were infected.

I can hardly think it necessary to adduce proof that the tubercle bacillus is in all cases of tuberculosis the active agent of the infection. Recent investigations, especially those of Cornet, have shown the manner in which infection occurs. The breath of consumptives contains no bacilli, and is not infective. Even when the lungs are full of broken-down tissue swarming with bacilli, the latter are only in the rarest instances, if at all, exhaled in the breath. Of course, during a fit of coughing, small particles of pus and secretion containing bacilli may be carried along in the forcible expulsion of air from the lungs, but even this is probably rare. Ordinarily the air of rooms or of hospital wards occupied by consumptives is free from bacilli and may be breathed with impunity. It is only when the dust of the room, containing dried and pulverized sputa, is disturbed by sweeping, or shaking up the bed-clothing, or in other ways, that danger of infection occurs. Scrapings from the walls of rooms occupied by consumptives, inoculated into animals, produced tuberculosis in twenty per cent. of the latter. Control experiments showed that dust from the walls of houses, hospital wards and public buildings not inhabited by tuberculous patients was not infective. Cornet showed also that the dust from the walls was in no case infectious when sputum cups were used to receive all expectoration was full of bacilli. Praussnitz has demonstrated the presence of tubercle bacilli in the scrapings of the interior of railway carriages on one of the German railway lines carrying many consumptive passengers. Thus is experimentally de-

monstrated a danger to which attention had previously been forcibly drawn by Whittaker, Gihon and others.

It is generally agreed among physicians that if the stools from a case of tpphoid fever are disinfected before being thrown out where they may contaminate the drinking-water supply, there is little if danger from further infection. The alvine excreta being recognized as containing the infective agent, the destruction of the latter renders the material innocuous. In like manner it may be accepted as demonstrated by recent researches that if the sputa of a case of consumption be disinfected as soon as expectorated the consumptive patient is no longer a source of danger to his neighbor.

From the foregoing it becomes evident that the principal measures of prophylaxis against tuberculosis must be such as comprise, first, immediate destruction of the bacillus tuberculosis in the sputa, or in other excretions when the case is not a pulmonary one; second, the disinfection of clothing and bedding, or other furniture liable to be contaminated with the infective material. As accessory measures must be considered notification to the health authorities of all cases of consumption, public disinfection of infected houses and conveyances (ships, railway cars) and the establishment of special hospitals for the free treatment of indigent consumptives.

The first example of an attempt at a thorough-going restriction of tuberculosis is the decree of the King of Naples in 1832, before referred to. According to De Renzi, quoted by Flick, this decree contained the following propositions:

1. The physician shall report the consumptive patient, when ulceration of the lungs has been established, under penalty for the first offence of 300 ducats, and upon repetition, of banishment for ten years.

2. An inventory shall be made by the authorities of the clothing in the patient's room to be identified after his death, and if any opposition shall be made, the person doing so, if he belongs to the lower class, shall have three years in the galleys or in prison; if to the nobility, three years in the castle and a penalty of 300 ducats.

3. Household goods which are not susceptible shall be immediately cleansed and those that are susceptible shall at once be burned or destroyed.

4. The authorities themselves shall tear out and replaster the house, alter it from cellar to garret, carry away and burn the doors and wooden windows and put in new ones.

5. The sick poor shall at once be removed to a hospital.

6. Newly built houses cannot be inhabited before one year from their completion, and six months after plastering has been finished and repairing has been done.

7. Superintendents of hospitals must keep in separate places clothing and bedding for the use of consumptives. Other severe penalties are threatened to those who buy or sell objects which have been used by consumptives, to servants, members of the family, and to any transgressors whomsoever.

The discovery of the bacillus tuberculosis and its mode of propagation and transmission would almost seem to justify these harsh regulations. Indeed, their enforcement appears to have produced a marked reduction in tuberculous diseases. Dr. Flick, who has made a very thorough study of this question, estimates that in 1782 the mortality from tuberculous diseases in the Kingdom of Naples was ten per thousand of population. In 1887 the official statistics for the Italian States formerly comprised under the Neapolitan Kingdom showed that the death-rate from all forms of tuberculosis was only 2.05 per thousand living people.

The efficient carrying out of restrictive measures against consumption requires intelligent coöperation on the part of the public. Hence, the education of the laity upon the infectious nature of tuberculosis and the importance of individual measures of prophylaxis must precede any successful enforcement of the legal enactments looking toward the restriction of the disease. There can be no doubt that the public press can give most effective aid in spreading such knowledge. The newspapers are always foremost in the dissemination of useful information. The press is the most powerful auxiliary of the sanitarian. The press makes public opinion. Public opinion makes laws, and until laws have the sanction of public opinion, it is futile to look for their successful enforcement.

Popular societies, like the French "Ligue prèventine contre la phthisie pulmonaire," and the "Pennsylvania Society for the Prevention of Tuberculosis," are

also useful and effective agencies in educating the people upon this subject. The organization of similar societies should be encouraged elsewhere.

Our current knowledge of tuberculosis and its means of prevention was effectively summed up in a report made to the New York City Health Department in the early part of 1889, by Drs. T. M. Prudden, H. M. Biggs, and H. P. Loomis, the pathologists of the department, and extensively published. In 1890, the Prussian Government issued a set of regulations which admirably cover the whole subject. This action was followed by the Kingdom of Wurtemberg in 1892. In the same year the State Board of Health of Michigan issued a pamphlet giving instructions for the disinfection of sputa, and in 1893 the same Board went a step farther and adopted a resolution requiring consumption of the lungs and other tubercular diseases to be reported among "the diseases dangerous to the public health," this report to be made by householders and physicians to the local health officer as soon as the disease is recognized. The purpose of such report is to secure to the health officer information of the location of each case, "with the view of placing in the hands of the patient reliable information how to avoid reinfecting himself or herself, or giving the disease to others, and and in the hands of those most endangered, information how to avoid contracting the disease."

The publication of the report of Drs. Prudden, Biggs and Loomis seems to have been the first official notification to the public by any health authority of the infectiousness and preventability of tuberculosis, since the Neapolitan decree before quoted. Within a few months the New York Health Department has taken a more aggressive step, and now requires "all public institutions, such as asylums, homes, dispensaries, etc., to transmit to the Board of Health the names and addresses of all persons suffering from pulmonary tuberculosis within seven days of the time when such persons first come under observation." Physicians are requested to notify the Board of all cases coming under their professional care. Hospital authorities are urged to separate consumptive patients from those sick of other diseases. Special inspectors are appointed to visit the residences of consumptives, deliver printed instructions containing methods of prevention, and practice disinfection when required. One of the municipal hospitals is to be set aside as a "Consumptive Hospital" for the exclusive treatment of this disease, and whenever requested by physicians, the Health Department will undertake the bacteriological examination of the sputum in doubtful cases.

Action in a similar direction was contemplated by the Board of Health of Philadelphia, but objection on the part of some physicians to the compulsory notification of the disease was strong so that it has been for the time abandoned.

Within two months the State Board of Health of Washington has placed consumption among the diseases required to be reported to the Board.

The Board of Health of the City of Baltimore is about issuing a circular to the public, giving suggestions in reference to preventive measures against tuberculosis.

The Pan-American Medical Congress in session in Washington last September, adopted resolutions recommending to the various National Governments represented, effective measures for the restriction of the disease, and the American Public Health Association, which has been studying the question for the past four years through a special committee, set its stamp of approval upon the work of the Committee, by the adoption of the following report and recommendations in Chicago last October:

1. "Tuberculosis has been conclusively demonstrated to be contagious, by bacteriological experiments, by clinical observations, and by a study of the history of the disease.

2. "Tuberculosis is a preventable disease. Its preventability follows as a logical sequence upon its contagiousness, but has likewise been demonstrated in practical life.

3. "The contagium of tuberculosis resides entirely and solely in broken-down tubercular tissue. A person suffering from tuberculosis, therefore, does not become a source of danger to others until he begins to give off broken-down tubercular tissue, either in the form of sputa from the throat or lungs, diarrheal discharges from the bowels, or matter from a tuberculous sore such as lupus, white

swelling, cold abscess, scrofula or tubercular inflammation of a joint.

4. "A person suffering from tuberculosis can be made entirely harmless to those about him by thorough sterilization of all broken-down tissue immediately upon its being giving off. With proper precautions it is therefore possible to live in the closest relation and upon the most intimate terms with consumptives without contracting the disease.

5. "Tuberculosis is not hereditary. A predisposition to the disease can be transmitted from parent to offspring, but this is more true of tuberculosis than it is of all other contagious diseases.

6. "A predisposition to tuberculosis can be created anew by malnutrition or by anything which depresses the nervous system.

7. "Tuberculosis affects animals as well as man, and is identically the same disease in both. In domestic life human beings and animals mutually infect each other.

8. "The media through which human beings are ordinarily infected by animals are milk and meat.

9. "Houses in which consumptives have lived and in which immediate sterilization of all broken-down tissue has not been practiced, are infected houses and are liable to convey the disease to subsequent occupants.

10. "Spitting upon floors and into handkerchiefs, and permitting the broken-down tissue to dry and become pulverized, is a prolific cause of tuberculosis.

11. "Temporary occupation of hotel rooms, sleeping car births and steamer cabins by consumptives in the infectious stage can infect them so as to convey the disease to subsequent occupants, unless proper precautions are taken against contamination of the bedding, furniture and walls with broken-down tubercular tissue."

We recommend the following practical measures for the prevention of the disease:

1. "The notification and registration by health authorities of all cases of tuberculosis which have arrived at the infectious stage.

2. "The thorough disinfection of all houses in which tuberculosis has occurred, and the recording of such action in an open record.

3. "The establishment of special hospitals for the prevention of tuberculosis.

4. "The organization of societies for the prevention of tuberculosis.

5. "Government inspection of dairies and slaughter-houses, and the extermination of tuberculosis among dairy cattle.

6. "Appropriate legislation against spitting into places where the sputum is liable to infect others, and against the sale or donations of objects which have been in use by consumptives unless they have been thoroughly disinfected.

7. "Compulsory disinfection of hotel rooms, sleeping-car berths and steamer cabins which have been occupied by consumptives, before other persons are allowed to occupy them."

The City of London Hospital for Diseases of the Chest, the North London Hospital for Consumption, the Royal National Hospital for Consumption, the National Sanitarium, the Manchester Hospital for Consumption and the Victoria Dispensary for Consumption, issue instructions to be observed by their patients to prevent spreading the disease. These all comprise the use of spit cups, disinfected cuspidors, the prohibition of expectorating on the floor indoors, or on the ground out of doors, and the avoidance of swallowing the sputa to prevent reinfection.

In the various sanatoria for tuberculosis in Germany and in many in this country similar instructions are issued. Some progressive private practitioners in this country have had cards printed containing concise instructions for the disinfection of sputa, and other measures to prevent the further spread of the disease.

The various practical measures for the restriction of tuberculosis may be summed up as follows:

1. Notification to the health authorities of all cases of tuberculosis, more especially of tuberculosis of the lungs. This report should be made by the physician who becomes cognizant of the case in the line of his professional duty, and by the householder himself. In order to reach all cases, such notification should be compulsory. While it is probable that some cases would escape report through the negligence or willful disregard of the medical attendant, these would be few and would diminish as soon as the benefits accruing from attention to this regulation became apparent.

2. All public institutions, as hospitals, prisons, schools, asylums, etc., should be required to promptly report through their managers or executive officials, under penalty, all cases of tuberculosis occurring in such institutions.

3. Upon the recovery, death or removal of a consumptive from one house or apartment to another, notice should be given by the patient or his guardian, the householder or the physician, to the health authorities, in order that appropriate measures of disinfection of the vacated premises may be taken.

4. Concise instructions for the guidance of patients with pulmonary consumption, or persons coming into frequent contact with them, should be furnished free of charge by the health authorities, upon notification of a case, or at the request of any person interested. These instructions should cover especially the means for destroying or rendering innocuous the sputa. The isolation of patients is not necessary; when the material containing the tubercle bacilli—in these cases the sputa—is destroyed, the consumptive is no longer dangerous to his most intimate associates.

5. The health authorities should be empowered to employ special inspectors to visit all cases of consumption reported, instruct the patients themselves and the family, or those brought closely and constantly in contact with them in the best means of avoiding self-infection and the communication of the disease to others, and to disinfect the apartments occupied by the consumptive if found necessary. It may be objected that this will interfere too much with the rights and privileges of the attending physician, but the latter would doubtless often be willing to be relieved of the tedious details necessary. There could, of course, be no objection to the attending physician performing these duties himself, provided they were thoroughly done.

Neither the inspector nor any other officer of the health department should be allowed to comment on the physician's treatment or to offer any suggestions in this particular. I believe it will be generally conceded that sanitary officials conduct themselves with tact and discretion in their relations with physicians.

6. Municipalities should be urged to establish special hospitals for the treatment of indigent consumptives. General hospitals should provide special wards for patients with this disease, and enforce in them the proper measures for the limitation of infection.

7. Railway and steamship companies should be required to change and disinfect all bed linen and other materials liable to infection from consumptive travelers.* Dr. Albert L. Gihon, in an address before the Pan-American Medical Congress, has graphically referred to the danger in steamship travel with consumptives, and Dr. J. T. Whittaker has pointed out the many sources of possible infection in the Pullman car.

Such are, in outline, some facts and suggestions that I have thought not inappropriate to present to you on this occasion. The facts are vouched for by leading investigators, physicians and sanitarians. The suggestions are legitimate deductions from the facts recorded. No one who studies the question without prejudice can resist the conviction that tuberculosis, "the great white plague" is a preventable disease; that by concerted action on the part of physicians, sanitary authorities and the public, it can be stamped out among all civilized peoples; that, like leprosy and the black death, it should be of interest in the future merely to the historian of human progress.

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THE STUDENT WAS PASSED.—Professor Rudolf Virchow, rector of the University of Berlin, is a small man with a dry, parchment-like skin and wears very powerful spectacles. The clothes that the learned professor wears are sometimes such as no old-clo' man would invest in. On one occasion he began the examination of a student by abruptly asking: "What color is my coat?" The student paused for a moment, and then replied: "Apparently, Herr Professor, it was originally black. Now, it seems to be of a bluish tint," for which reply he was passed.—*San Francisco Argonaut.*

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SUCCESS AT LAST.—"You say she tried to stop a street-car by whistling at it. Did she make a success of it?"

"Yes, in a way. It wasn't her whistling that stopped the car, though; it was the face she made."—*Indianapolis Journal.*

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* It is reported that on one of the Hungarian railway lines, special railway cars will be furnished for consumptives. These will be renovated and disinfected after each trip.

# THE TREATMENT OF SCOLIOSIS, AND THE BRANDT METHOD OF PELVIC MASSAGE.*

MATHILDA WALLIN, M. D., New York City.

As I am not able to enter into details, nor would be able to give a good description of the movements generally used in the treatment of scoliosis by medical gymnastics, I thought a practical demonstration would be best, as Dr. Lewis has kindly provided me with a scoliotic patient.

The fact that the treatment of scoliosis with bandages and apparatus only is not sufficient for cure of this disease, is more and more realized. . "If we cannot *make* a spinal curvature straight, we can possibly compel it to *grow* straight," and this is done by no other means so well as by medical gymnastics, *i. e.*, exercises arranged to suit each individual case, which will correct the faulty carriage and develop the whole muscular system, combined with the necessary supports. And if a scoliosis is taken early enongh it can be cured. The condition which is the most injurious to health, the most disfiguring, and the hardest to affect by any treatment, is where rotation of the vertebræ has taken place. But even this kind of scoliosis, if discovered early and placed under treatment, can be stopped in its development, and even be cured.

The best results in the treatment of scoliosis I saw obtained were at Dr. Tidemand's Orthopædic Institute, in Christiania where the so called "self-correcting, or self-straightening method" was used. Besides these "self-straightening" movements, by which the patient herself, by her own effort of will, straightens the spinal column. Swedish medical gymnastic movements are given, and the patient rests on a hard bed after each set of exercises; the whole Institute being ideally arranged to carry out the treatment. This treatment is hardly known outside of Norway.

Dr. Zander, whose remarkable genius has been at work even in this direction, has invented some excellent machines for the treatment of scoliosis, which ought to and do give splendid results. His apparatus for measurement of the body and of the spinal column, in order to obtain correct diagnosis, is the best, the most correct, and the most ingenious that was ever invented, and no orthopædic hospital is complete without it.

I want to say a word concerning the prevailing idea that slight degrees of scolioses only need general straightening exercises, equal for both sides, which can be given in a gymnasium. I think that is wrong. Even in Sweden, where there are no other than trained teachers in gymnastics, who have, at the same time studied medical gmynastics, it is not done.

The use of massage and movements as therapeutic means in gynecology was first introduced by Major Thure Brandt, who is one of the most meritorious Swedish gymnasts now living; he has for over thirty years, with indefatigable care, used, and more and more developed the discovery he made, and forced it, so to speak, through hard and energetic labor, upon the attention of physicians. The distrust and suspicion he met from the medical world, in whose "more worthy and skillful hands" he, in vain, tried to place his discovery, did not diminish his energy and courage, but he was compelled by the hostile position of physicians to work on independently and alone, carry out his researches, enlarge his experience and improve his technique. In 1872, his work was to be subjected to an impartial and scientific test by Dr. Sköldberg, a gynecologist of great promise and ability; but he died suddenly just as he was to begin his examination of the work. After that, Brandt, with persevering energy tried to introduce the method among physicians, although with no great success until 1886, when the test—objective, impartial, and scientific—was given to this treatment. Then Brandt, at the proposal of Dr. Profanter, went to Jena, and there under the careful control of Professor Schultze, treated a number of cases personally by his own method.. The published results—which are to be found in Dr. Profanter's book, *Die Massage in der Gynäkologie*—show that it stood the test and was given the recognition it deserved. Having had the great privilege of being Major Brandt's pupil and assistant for

* Read by invitation before the Philadelphia County Medical Society, March 28, 1894.

three years, I consider it a means of showing my appreciation and gratitude to be able to speak to you this evening. In trying to spread the knowledge of this most valuable means of treatment in gynecology by calling the attention of the profession to the subject, I am enabled to pay some of the debt I owe this remarkable man for what he has patiently and kindly taught me.

In this work of Dr. Profanter's you will find that he claims for Brandt's treatment a value above every other, but it remains to be made clear *when* this treatment is advisable and also to familiarize specialists with its technique.

The question whether the technique can be so described in print that a physician can appropriate and make use of it without actual demonstration has often been discussed, and I dare not venture to say that it is absolutely impossible. The treatment is difficult. It is difficult because a great deal of practice is required to familiarize ones self with it, and, after the theory and practice are acquired, it is still not only difficult but exhausting. Then, too, it requires judgment to adapt and moderate the treatment to the nature of the case. I am inclined to think that the reason why so few who have tried the treatment have been successful is because they have not had sufficient experience in its technique. They have thought themselves competent after a week or a few weeks' study with Brandt, and after trial with a few cases, to render a verdict on the method.

It has been considered impossible that Brandt, a layman, should be able to carry out a treatment of any value, which every physician ought to be able to do better. I think that Dr. Lindblom—one of Brandt's pupils—is right when he says: "If Brandt had not been a layman he would not have made his discovery, or, if he had made it, he would not have pursued and developed it as he did. His ideas would then have probably been confined to the certain paths of professional investigation and his treatment adapted to the existing status of gynecological science."

His theoretical knowledge is far from mean, and his ability to quickly and accurately palpate the pelvic organs, and there find deviations from the normal, every specialist has reason to envy. Being self-educated in this line, he has been prevented from entering into the whole scope of gynecology, not to say of medicine, so he is often lacking in ability to give a scientific differential diagnosis sufficient to satisfy a fastidious man of science; but in diagnosis by palpation he is a *master*. He does not, as some writers affirm, claim great and wonderful results for his treatment, nor that his method is a universal remedy for the diseases of women. I have seen him again and again send patients away whom he found on examination he could not help. As for his claiming wonderful results, everybody who has had the fortune to know Brandt says that he is a most modest and humble man, equally willing to give and to receive information.

Brandt's method consists in general and special treatment; the first is not considered necessary by many physicians, but Brandt himself, as well as those who have used the treatment for a longer time, consider it a most valuable adjunct. Many patients suffer from other complaints besides the pelvic disease which the general treatment by medical gymnastics improves and cures; and this may be one of the reasons why in Brandt's patients the subjective improvement is quicker than an objective examination would indicate. In the selection of movements for the general treatment, their effect upon the pelvic organs is first considered, and no movements are chosen which would in any way counteract the effects of the special treatment.

Brandt's method of examination differs somewhat from the ordinary. The patient is always first examined in the standing position, by which the physician is enabled to ascertain the lowest position of the uterus, as it is by its own weight, and by the parts above, pressed downward, and is then in some measure easier to palpate. In some cases the uterus is retroverted when the patient is lying down, and anteverted when she is standing, which he is able to find out only by this mode of examination. Then the patient (with her clothing unfastened around the waist, but otherwise perfectly covered) is placed upon a couch slightly lower than the chair on which the physicians is sitting, her head raised, her legs flexed and abducted, thus relaxing the abdominal walls. The physician sits on the patient's left side, near her pelvis with the face turned toward

that of the patient. Then his left forefinger is passed under the left thigh of patient into the vagina up to the posterior cul-de-sac, thus enabling him to palpate the organs, ascertain their position and condition, lift the organs or parts that require massage, and support them against the abdominal wall and the right hand by which he manipulates externally. The left hand is held open, that is, the three last fingers are placed under the buttock, or along the perineum (because in this manner he is able to reach higher), the thumb to the side, removed from the symphysis pubis, the forefinger pressed as far as possible against the posterior wall of the vagina and kept immovable in the vagina. By the three middle fingers of the right hand, the operator then makes pressure through the abdominal wall, executing the different manipulations indicated by the pathological conditions, and which will be described later. In young persons and virgins, the needed support in the treatment is given by placing the forefinger in the rectum instead of the vagina.

Brandt prefers and uses the low couch instead of the ordinary table, because it is less fatiguing to sit and have the patient lower than himself, thus giving freer motion to his arm and enabling him to work without getting too quickly tired.

The special treatment consists of—

1. Massage of different varieties.
   - *a.* Vibrator pressure or strokings.
   - *b.* Small circle kneadings or strokings.
   - *c.* Large kneading or roll kneading.
   - *d.* Vibratory pressure—strokings.
2. Stretchings.
3. Reposition: different varieties or methods.
4. Lifting { *a.* Uterus. *b.* Sigmoid flexure.
5. Movements for constipation (if indicated.
6. Complex of derivative and inciting movements.
7. Knee abduction.
8. Nerve movements.

Massage should be begun very lightly and at the first *never* directly on the diseased part, but on surrounding parts and on the side nearest the vascular centre, so to stimulate the vessels to greater activity and insite greater resorption of the exudative residues. Brandt always strongly emphasized "rather too little, than too much." The lighter massage, the small circular kneadings, are produced by the three middle fingers of the external hand (care being taken to use the soft parts of the finger tips) pressed lightly through the abdominal wall on the organs within the pelvis in such manner that the integument and underyling tissues follow the fingers. The organs must be supported and sometimes somewhat lifted in order to meet the external hand, by the finger introduced in vagina or rectum, as the case may be. The circular kneadings are produced by small, quick, circular movements of the finger tips, at the same time gradually advancing, if possible, in the centripetal direction of the lymph-currents, using simultaneously all the joints of the arm, which makes the movements lighter and, so to speak, softer, and does not so much actually knead as squeeze and soften the exudates or residues which may be present.

The massage should be begun with light pressure, gradually increasing somewhat, and ending by some lighter strokings and letting the hand rest a few moments on the abdomen, which seems to disperse the unpleasant feeling the movements may have produced.

Indications for the lightest massage are:

1. Menorrhagias in which the whole uterus is masséed, though only for a short time; the treatment may be repeated more than once a day.
2. Atrophy of corpus or of isthmus; the atrophied parts being masséed.
3. Chronic endometritis.
4. Before and after the uterine liftings.

The indications for relatively stronger massage are:

1. Peri- and parametritic exudates or exudative residues, in which case we begin the massage at the periphery, especially on the side toward which the lymph-vessels go, and later, going gradually toward the centre.
2. Adhesions and sensitive scar-retractions in the connective tissue.
3. Massage is also always given after stretching on the stretched part.
4. Chronic metritis; the massage in these cases is executed on the corpus from the fundus toward the isthmus, from the sides toward the middle, and on the cervix from downward up, besides on the broad ligaments partly along the sides of the uterus, partly from uterus toward the sides of pelvis.

If possible, during the massage of the uterus, it should be anteverted. That massage can be given on a retroverted or retroflexed uterus, where adhesions prevent its reposition, is understood; but the anteverted position is preferable, and reposition should always be made first when the uterus is movable; the only exception is if the position should cause irritatian of the bladder when it is kept retroverted.

5. Cervical catarrh and enlargement, in which the massage is made downward toward the isthmus.

6. Massage is also often given before and after reposition in displacements on one or more of the uterine ligaments.

7. Chronic oöphoritis or peri-oöphoritis, when the ovary, as well as the surrounding parts, especially upward and backward, are masséed.

A differential diagnosis can often be made between oöphoritis and peri-oöphoritis through the result of the treatment; in the latter, where the enlargement of the ovary is due to swelling of the surrounding tissues, it is especially amenable to treatment; the former is not so much so.

The contra-indications for the stronger massage are:

1. The acute inflammatory character of the disease.

2. Menorrhagia and metrorrhagia.

3. Amenorrhœa; massage on the corpus is contra-indicated in these cases.

The larger and often quite powerful kneadings with the whole hand, roll frictions or kneadings with the palm of the hand through the abdominal wall, are used on a very enlarged uterus or on very large and hard exudate where all inflammation has disappeared.

The manipulation which Brandt—for lack of a better word to describe it—calls "paintings" (German, "malen") is a kind of curved-shaped stroking, produced by the forefinger in the rectum, along the pelvic wall in direction from downward upward, or from forward backward, according to the direction of lymph-vessels and veins. It is indicated in inflammatory conditions (not too acute) or exudations in the uterus or ligamenta lata.

Stretching is produced either by trying bimanually to seize the contracted or adherent part and gently stretch it; or bimanually by taking hold of the adherent uterus or ovary and trying to free it; or by passing the finger up into the rectum, behind or above the adhesions, and gently and continuously press the uterus, first on one, then on the other side of the contracted and adherent part. This can be done with the patient standing, lying, or in the knee-chest position, always remembering to observe the patient so as not to do too much at one time.

The indications for the stretchings are:

1. Peritoneal adhesions, principally between the uterus or the ovaries and other parts of the pelvis.

2. Scar-retractions in the pelvic connective-tissue.

Contra-indication to stretchings in inflammatory conditions of the parts.

Repositions are produced in different ways, according to the deviations of the organ, and it would take too long a time to enter into a description of its different modifications. They are indicated in:

1. Deviations of the uterus, when it produces discomfort or sterility.

2. To improve the position of the uterus for a more effective massage.

Contra-indications: Firm and sensitive adhesions or retractions.

Uterine lifting is indicated in:

1. Prolapsus uteri (of all degrees).

2. Prolapsus vaginæ, with cystocele and rectocele.

3. Retroversion and flexion.

4. Anteversion (with some modification adapted to the case).

5. Latero-version (with some modification adapted to the case).

The contra-indications are:

1. Para- and perimetritis.

2. Oöphoritis.

3. Menorrhagia.

The modus operandi, which is hard to describe, is the following:

If there is prolapsus the uterus is restored to position in the usual way, and when that is done the so called "double-treatment," or the lifting, begins. The uterus is supported in the vagina by the forefinger of the physician placed on the vaginal portion. A woman assistant then kneels down on the couch between the knees of the patient, places both of her hands flat on the abdomen, their ulnar sides touching each other; the physician first placing his free hand on the abdomen, and pushing the integument from above downward, to guide the assistant and give her a kind of grip, so to speak, of the uterus; then she presses her finger-tips

down in the pelvis, in front and to the sides of the uterus, slightly flexes the fingers, grasps the uterus and lifts it and its adnexa upward, and lastly, somewhat forward, following the axis of the pelvis. The physician with his finger on the vaginal portion, follows the movement of it during the lifting as far as it is possible to reach, and presses it backward. These "liftings" are repeated three times, after which Brandt gives some light massage, as said before, by which he tries to stimulate the hypogastric plexus and the posterior portion of the sacro-uterine ligaments of both sides.

These liftings are modified according to the individual case and its need; and the "liftings" are never given when the uterus is retroflexed or retroverted.

If cystocele is present he gives a vibratory stroking pressure on the relaxed protruding part, the strokings being made upward and inward by the tip of the index finger, avoiding the urethra.

When this procedure is completed the patient lifts her buttocks and the lower part of her back from the couch, supporting herself with her neck and upper part of her back, as well as by the feet resting on the couch and with closed knees. The physician then separates her knees while she resists, and she closes them while he resists.

The purpose of these exercises is to strengthen the pelvic floor, especially the levator ani.

The patient is then given light tapotement over the sacrum.

How this method produces cure in displacement and prolapsus has been discussed a number of times, and many theories and explanations have been given. Dr. Boldt says that Schultze considers the cause to be contraction of the sacro-uterine ligaments. Whatever the cause may be, the cure remains a fact.

The exercises given to the abductors of the thighs are an important factor in producing the desired results.

In the summer of 1882 I saw the first complete prolapsus uteri cured. The woman came to Brandt the 29th of June; the 11th of July the uterus was retained within the body, although the anterior wall of the vagina protruded on exertion; the 9th of September she was well, with the uterus in normal position.

That this treatment of prolapsus exerts a powerful curative influence every one who has followed it, or tried it, must fully recognize.

As said before, movements are given to every patient to improve her general health.

I sincerely hope by this paper to call the attention of the profession to this valuable therapeutic means, so well known in this country, and always looked upon with prejudice and suspicion, which it deserves as little as any other treatment, when undertaken by skillful operators. The investigations concerning and acceptance of it by a man of such standing in the scientific world as Professor B. S. Schultze ought to be an unquestionable and sufficient guarantee of its efficiency.

However many theories there may be, however many objections there may be raised, the efficacy of the treatment in indicated cases remains a fact, which neither objections or theories have the power to overthrow, and this fact I have been able to observe for a long time. In certain cases especially adapted for this treatment I have seen no other which can compare with it. Larger experience and further investigations will show the truth of this, as well as give more definite conclusions as to its indications and contra-indications.

And, lastly, I will quote the following words from Dr. Levertin, which I think are fitting in this case also: "I ardently wish that nobody may see, in these descriptions, the expression of excessive enthusiasm only, but rather the conviction of an unprejudiced critic desiring to make profelytes to his doctrine confirmed by experience among more or less skeptical colleagues."

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A TORONTO woman, after burying her seventh husband, erected a monument to the whole lot. It consisted of a marble hand with the index finger pointing to the sky, and on the base instead of names, ages, etc., were the words, "seven up." —*Exchange.*

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Housekeeper—"How are eggs this morning?"

Mr. Gruff Grosser—"High."

House-keeper.—"When are they going to come down?"

Mr. Gruff Grosser—"When they are hatched."—*Boston Courier.*

# COMMUNICATIONS.

## CONDITIONS JUSTIFYING REMOVAL OF THE TESTICLE IN RADICAL OPERATIONS FOR INGUINAL HERNIA; WITH A REPORT OF THREE SUCCESSFUL CASES*

THOMAS S. K. MORTON, M. D.,† PHILADELPHIA, PA.

FELLOWS OF THE ACADEMY OF SURGERY: Prior to making my remarks upon the above subject I desire emphatically to press the fact that I am not here to advocate the indiscriminate sacrifice of an organ usually so highly prized as the testicle, but simply to point out certain of the conditions which would appear to me to justify the procedure and to relate three cases in which I have considered it best to resort to it. These cases represent the total number in which I have deemed it prudent to add ablation of the gland to formal procedures for the radical cure of inguinal hernia, for instances are rare in which this course may be considered justifiable, and must become constantly more and more so as radical procedures become perfected.

With the operations proposed by Bassini, Postempski, and Halsted, with their modifications, where the cord is displaced entirely from the inguinal canal, and, in the latter, even removed from the internal ring to an entirely new opening made for the purpose in the muscular structures of the abdominal wall; with these operations, I say, the presence of the cord has almost ceased to be a hindrance to seemingly ideal radical cure. Hence any temptation to sacrifice the testicle vanishes, and the conditions necessitating or permitting such removal become correspondingly more circumscribed.

Removal of the testicle in operations for inguinal hernia would, therefore, in my estimation, be practically limited to the following conditions:

1. Certain cases of undescended testicle.

Here, if the testicle had entered the canal and was degenerated or otherwise diseased, or could not be separated from the sac without endangering its vitality, or where it was manifestly functionless, it might be removed without reluctance. But if it were normal, or almost normal in all respects save position, it would be best, if possible, to displace the cord from the canal by one of the modern methods and attempt to bring the organ into the scrotum and there fix it by sutures; or it might be pushed within the abdominal cavity through the internal ring, and there permitted to remain after close suture of the ring.

2. In some rare cases of congenital hernia.

Removal here must be very exceptionally called for with so many modern operative resources at hand.

3. In certain cases of chronic or acute disease of the testicle or cord complicating hernia demanding removal of the organ upon its own account.

4. In rare cases in which severe traumatism has occurred to testicle or cord during or before operation.

Accidental division of some or all of the vessels of the cord would not necessarily demand excision of the testicles unless other severe complications were present. Wounding or section of the vas deferens likewise might be consistent with retention of the organ. But where the gland has been stripped entirely from all other connections such injury to its vascular supply would produce so much danger of necrosis that ablation would become imperative.

5. In certain cases where sloughing of the sac or interrupted circulation of the cord or testicle has involved these latter structures in a suppurative or sloughing process.

6. Perhaps occasionally in the very aged, to simplify or shorten operation, or for some of the before-mentioned conditions of less degree than would justify the procedure in a younger individual.

There are no conditions of course, except senility, that would excuse the removal of a testicle under circumstances

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where it was the sole reproductive gland possessed by the individual; even more rare would be the conditions justifying removal of both testicles in double herniæ.

Surgeons must be exceedingly cautious not to interfere with so highly-valued a part without either a very clear understanding with the patient before witnesses (and preferably in writing) preliminary to the operation, or else be certain that the conditions for which the organ is removed will be convincing to others of the necessity for such removal. It is obviously important also for the operator to carefully preserve the specimens for his protection in case of dispute.

One word more of caution. It is not the easiest matter to tie off the testicular cord in such a manner as to leave it absolutely secure against recurring or secondary hemorrhage after its return to the abdominal cavity; and bleeding from it originates a peculiarly dangerous form of shock quite independent of the amount of blood lost, which often is speedily fatal. Moreover, the bleeding will not be likely to cease spontaneously in the warm and most peritoneal cavity to which the ligated stump has been returned, and operation to secure it more firmly (if diagnosis is made in time) would be a very formidable complication. Hence, excessive care must be exercised in its primary ligation. It should be transfixed and tied off in at least two portions. Silk is the only fit material for this purpose. A good button of tissue should be left above the ligatures, and, to be doubly sure, any apparent vessel ends should be separately ligated upon the end of the stump before it is returned to the cavity. Searing the stump with a cautery below the main ligatures would be equally, perhaps more efficient than the separate ligatures to the vessel ends. If the cord were very large or œdematous it should be ligated in even smaller portions.

Case I. *Huge Strangulated Inguinal Hernia; Radical Operation with Removal of the Testicle; Recovery.*—Mr. M. C. B., a strong, healthy man of nearly fifty-seven years, strained himself fourteen years ago whilst pulling a heavy satchel across the floor. It caught on a splinter, and, as a result of straining to dislodge it while in a stooping position, he felt something give way in the left groin, and became exceedingly faint. Shortly after this a small, reducible, but constantly reappearing tumor, came into the scrotum, and, as time went by, became gradually larger and larger.

Several years after the first appearance of the tumor, and when it had attained quite a large size, he became subject to occasional attacks of strangulation, which always required anæsthesia for reduction. Then, after one of these attacks, a large portion of the tumor became irreducible, and so remained. After this when the seizures came on strangulation could always be overcome by reduction of a portion of the hernial contents, but the entire tumor could never be reduced. Several more attacks of strangulation occurred at varying times after this, when more intestine would become prolapsed, but relief was invariably obtained upon reduction of the newly prolapsed and strangulated portion. While strangulation lasted his chief symptoms was always an agonizing dragging pain at the epigastrium. By wearing a truss over the site of the external abdominal ring, that portion of gut which prolapsed and produced strangulation was more or less effectually kept up.

About 8 o'clock P. M., April 10, 1889, he felt the hernia slip out, and became a little faint and sick; but after lying down for a short time continued at his desk until midnight. At 1 o'clock A. M. he reached his home in West Philadelphia by street car and foot from the city. His sensations were then different from anything that he experienced before, and he was certain that he was about to die—on similar occasions he had always been most confident and hopeful. At 3 o'clock A. M. he was seen by the late Dr. Michael Lampen, who always heretofore had been able to reduce the strangulation by taxis. The doctor, therefore, promptly placed the patient under anæsthesia, but was unable to reduce the tumor after an hour's application of taxis. He, however, could not let up the ether on account of the man's terrific sufferings. Ether narcosis, with an occasional application of taxis, had been kept up continuously from 3 A. M. until 8 A. M., when I saw the case in consultation. The patient's condition at the latter time was fairly good, but he was much depressed by the prolonged anæsthesia. No fecal vomiting had occurred.

Upon examination an enormous left-sided inguino-scrotal hernia was discovered.

It was fully as large as a man's head; the skin covering it was exceedingly tense, shiny, and almost black from inguino-scrotal impeded circulation. Fluctuation was marked over the upper and outer portions of the tumor, whilst at that portion near the man's knees was present a large semiglobular boggy mass just beneath the skin.

Consent to operation having been obtained from the wife, taxis of a moment's duration was unsuccessfully employed, and operation at once proceeded with. Full aseptic measures prevailed throughout. A six-inch incision was made in the line of the tumor and inguinal canal, and carried down to the sac, which was punctured and torn to an equal extent. About a pint of brownish-tinged odorless serum escaped from the opening, and the small intestine at once came into view. This was highly distended with flatus, almost black, and in places ecchymotic. The constriction was then sought for and found to be at the external ring. This was incised upward, and the three feet of prolapsed small intestine was—after it had begun to assume a pinkish color—with some difficulty returned to the abdominal cavity, a healthy portion having first been pulled down at each extremity to make sure that no constricion existed at a higher or lower point. Attention was now turned to the remaining prolapsed mass. This had the appearance of being an enormously hypertrophied omentum, and was not in the slightest degree congested or strangulated. At first sight I took the mass for omentum; so great was its resemblance thereto, and it was only upon most careful examination that its true nature was revealed. It proved to be practically the entire colon, excepting possibly the cæcum, which could not be recognized in the confused mass, as well as the omentum attached. This discovery was made by finding deep, between two layers of fat, a band of fibrous material through which muscular fibres coursed, and, later, by feeling a small fecal mass in the lumen. The bowel was absolutely collapsed, practically free from feces, and deeply buried in hypertrophied surroundings. The mesocolon also participated in these changes, and was likewise rendered almost indistinguishable by fat deposit. Only a longitudinal half-inch strip of bowel could anywhere be brought to sight. The epiploic appendages were enormous. (An illustration that it should be an invariable rule to cut or ligate nothing about a hernia until absolutely sure of its nature.) The mass was separated from its many adhesions to the sac, but, from its great size, after separation could not be reduced through the abdominal rings, although these were very much dilated. Hence the incision was enlarged upward along the inguinal canal and the internal ring very freely divided upward upon the abdomen for a distance of several inches. The colon and omentum were then easily reduced, and attention turned to the sac. This was found universally adherent and particularly to the peri-testicular tissues. Its dissection was finally accomplished up to and within the internal ring, where it was cut off and the ends sutured together. I did not employ the method of dealing with the sac in this case that is advised by Macewen, because of the very large mass of perhaps devitalized tissue which would by that method have been returned to the abdomen. Where the sac is not very large, however, that procedure is quite a favorite with me.

The left testicle was elongated, hypertrophied, and so enveloped by the sac as to give it much resemblence to a prolapsed kidney, but examination quickly demonstrated its identity. After the sac had been dissected up it was found that the testicle was left without any vascular attachment excepting through the cord. Then arose the question whether it should be allowed to remain. This, again with the consent of the wife, was decided in the negative for the following reasons: the organ was much hypertrophied and œdematous, and likely would require more blood than could be conveyed to it by the perhaps bruised and occluded cord; the patient was fifty-six years of age; the opposite testicle was apparently quite healthy and normal; and, finally, a much more certainly radical operation could be done by having the cord out of the wound. Again, had the organ been allowed to remain its life was by no means certain, and its necrosis might have made a very dangerous complication during convalescence. Hence the cord was ligated just below the internal ring and the testicle cut away. After being very certain that every vessel of the cord was firmly occluded by the ligatures, the pedicle was dropped within the abdomen. A glass drain-tube was placed

in the extreme upper portion of the abdominal wound. Then a layer of deep sutures of chromic catgut were run along the muscular structure of the wound down to the internal ring, through that structure and down along the canal to and embracing the external ring, thus giving a secure and accurate opposition of all the parts concerned in the hernial opening unimpeded by the presence of the cord. Were I doing this same operation to-day I would probably not introduce the tube at all, but if it were called for, would insert it through a separate median opening just above the pubis. However, in this case no harm resulted from leaving the upper portion of the wound weakened by a drain-tube orifice. The entire skin wound was next approximated by interrupted silk sutures a double-spica bandage applied over a copious dressing.

As soon as consciousness returned he was put upon powders of calomel one-tenth grain, and podophyllin one-sixth grain every hour. These he took for twelve hours, and then was placed upon one-drachm doses of Epsom salts hourly. No food was permitted for twelve hours. Bowels moved very freely next morning with the assistance of an enema. From the time of coming out of the ether until the day following he was violently restless, pitching and tossing about the bed in an altogether uncontrollable manner. Somehow in the night he had, without the knowledge of those about him, managed to withdraw the drain-tube. This I found lying loose in the bed when I saw him early next day. The bowels by that time having freely moved and the belly being entirely flat, I determined not to replace the tube unless compelled to do so. Jactitation controlled by fifteen grain-doses of chloral.

April 15th. Belly slightly distended. Still somewhat restless; for this more chloral. Bowels have again moved very freely. Temperature has not been above normal. Violent bronchitis present as result of the prolonged anæsthesia.

16th. Abdomen much swollen, nausea and non-fecal vomiting; complains much of pain; racking hiccough present; bowels not moved to-day. Decided to reinsert tube. Removed stitch at extreme upper portion of the wound and put glass drain-tube down to hollow of sacrum, and through it drew off two ounces of turbulent, bloody, non-odorous serum. Wound in excellent condition. Again put bim on fractional doses of calomel and podophyllin. Bronchitis improving, but much purulent expectoration continues.

17th. Bowels freely open. Small amount of serous straw-colored fluid from tube. Hiccough and vomiting continue obstinately. For latter symptoms ordered cocain one tenth grain, oxalate of cerium two grains, and bicarbonate of sodium two grains, every two hours.

18. Vomiting and hiccough entirely under control. Bowels moved of their own accord, abdomen entirely flat and painless. Discharge had ceased, so tube was removed, as well as all the skin sutures. Patient eating and sleeping well. Bronchitis almost gone.

On May 4th he sat up and began to get about; in two weeks more was at his business again.

When seen about a year after the operation there was present a firm cicatrix and no sign of return of the hernia. Up to the last time that I heard from him, several years afterward, he continued entirely free from the return of the hernia. *Transactions of the Philadelphia County Medical Society*, 1889, p. 206.)

CASE II. *Large Strangulated Inguinal Hernia; Sloughing Intestine; Radicul Operation, with Removal of Testicle; Recovery.*—Jacob B., aged forty-three years, was brought to me by his physician, Dr. James Robinson, on March 6, 1893, and admitted to the Polyclinic Hospital. He stated that he had had a large tumor in the left scrotum from childhood, and could not remember when it had originated. By manipulation at times he thought that it had become somewhat smaller. It never had given him any annoyance.

On March 1st, while in apparently perfect health, he drank a quantity of ice-water, which induced vomiting, during which he felt a "giving away" sensation in the left inguinal region. From this time he continued to vomit everything taken and to experience extreme nausea. Bowels also ceased to move. The tumor became more and more painful and swollen. He continued in this condition five days, and then summoned Dr. Robinson, who applied taxis for thirty minutes without making any impression on the mass. On the sixth day he walked a number of squares to the hospital.

Upon admission I found a tumor the size of a large cocoanut occupying the left scrotum and inguinal canal. The testicle was below the general mass and could be outlined as distinct from it. The whole tumor was very tender and somewhat œdematous. Deep-fluctuation was marked. No percussion resonance, or succussion. A very resisting mass occupied the inguinal canal. Bowels has not moved for six days. Constant fecal vomiting. Condition very fair.

A diagnosis of chronic hernia of the ementum, with acute entanglement of a portion of the intestine, together with hydrocle of the hernial sac, was made, and immediate operation insisted upon.

After preliminary cleansing and anæsthsia, without waiting to make prolonged taxis, which was clearly prohibited by the long duration of the strangulation (as the subsequent history clearly demonstrated), a five-inch incision was made in the line of the inguinal canal and scrotum. The cellular tissues were œdematous and had some odor of decomposition. The sac was exceedingly thick and highly discolored, as if about to break down. It was freely incised, and half a pint of dark, turbid fluid of putrefactive odor escaped. The sac contained a large mass of hyperrophied omentum of the character so frequently found in omental hernias; it was adherent by firmly organized attachments to most of the sac-wall. It was purple in color, intensely congested, and very œdematous. The whole was stripped from its adhesions and carefully spread out, whereupon a portion of small intestine came into view that had been entirely wrapped up in the folds of the omentum. This again illustrates the extreme care that is always so necessary in handling the contents of a rupture; for it would have been exceedingly easy to have ligated off the omentum and bowel together in this case, and to have returned the stump to the abdomen, thus insuring a fatal issue. A finger passed into the inguinal canal discovered a very tight constriction at the internal ring, which was freely divided upward. The omentum could now be pulled down with ease until entirely healthy portions appeared, where it was ligated off in two bundles by transfixion, and the stump returned to the cavity and fixed immediately behind the internal ring by bringing both of the ligature ends through different portions of the muscular wall and then tying them down as suggested by Macewen for making a protecting pad of the sac in his radical operation. The prolapsed intestine could now be freely inspected.

Upon the free margin was a gangrenous spot one-half inch in diameter, which appeared to be in imminent danger of rupture. The remaining portions of intestine were almost black from venous stasis, but were not actually sloughing. The sloughing portion was buried under healthy peritoneum by means of Lembert sutures; buckled into the lumen of the bowel, as it were, just as if perforation had taken place. Fortunately this procedure did not too much diminish the lumen of the bowel; and by the time that it was completed all excepting the sloughing portions of the intestine had, under hot irrigation, resumed the beautiful pink tint of returning circulation. The bowel was then returned to the abdominal cavity.

After a very difficult dissection the sac was freed of its attachments to the scrotal, testicular, and cordal tissues, and ligated off in two sections at the internal ring. The stump of omentum was next fixed behind the ring as described. Attention was now turned to the testicle and cord. These structures were œdematous, had the general foul odor of all the surroundings, and, in spite of careful separation, had been considerably injured by the dissection and other manipulations. It was considered that leaving such structures in a wound already gravely threatened with suppuration, if not sloughing, was an unjustifiable risk to which to subject the patient, as the testicle, under these circumstances, was likely to break down and slough with accompanying dissecting suppuration, and especially was it desirable to secure for this hard-working man a radical cure if possible. Hence the cord was ligated at the internal ring most carefully by a transfixing double ligature of silk and also returned to the abdomen. This permitted a careful and complete closure of the internal ring and the whole inguinal canal by buried silkworm-gut sutures placed about three-eighths of an inch apart. A small rubber drain was placed in the lower portion of the scrotal wound, but none in the upper portion and the skin margins approximated by silk sutures.

Excepting a small amount of suppuration in the scrotum, the entire wound

healed by primary intent. The drain was removed on the third day. The bowels moved within twenty-four hours spontaneously, and naturally each day thereafter. There were some small clots of blood in the first stool, but none subsequently. He was given absolutely nothing by mouth for thirty hours subsequent to the operation; but rectal enemata of warm water were frequently administered, which prevented thirst. Then liquid diet was started and full diet gradually resumed. He was kept in bed three weeks, and resumed his duties as a hotel waiter in five weeks. He was instructed not to wear a truss.

I last saw this man on November 2, 1893. There was no sign of return of the hernia. The cicatrix was sound. He has been working hard at his occupation ever since the operation, has not worn a support, and expressed himself as stronger and better in every way than he had been for years.

CASE. III. *Strangulated Congenital Inguinal Hernia; Radical Operation with Removal of Undescended Testicle; Recovery.*—Irvin B., aged nineteen years, was admitted to the Polyclinic Hospital, May 9, 1893. He has enjoyed excellent health all his life, but always has had a "come-and-go" tumor in the right scrotum, and has never been able to distinguish a testicle upon that side. The opposite testicle is large and firm. The tumor could always be reduced with ease, and likewise disappeared whenever he laid down. It was painless. He had never worn a truss.

On the morning of May 8th, upon slight straining while at his work of tile-setting, he felt a painful and unusual sensation in the right side of the scrotum, and went home, nauseated and in great suffering. He then discovered that a tumor much larger than usual was present, and that it was tender and irreducible. The bowels moved a few hours subsequently.

On May 9th he applied to me for relief, and I insisted upon his entering a hopital. No movement of bowels except shortly after strangulation. Much nausea and anorexia, but no actual vomiting had taken place. Belly somewhat distended, but general condition good. In the right inguinal region was a tumor of considerable proportions and very sensitive. Fluctuation was very marked in the dependent portion of the scrotum. No succussion; no percussion resonance. Inguinal canal tense and occupied by a solid mass. Testicle could not be defined.

The man was given a bath upon admission, and, consent to removal of the undescended testicle having been secured, immediately etherized. Taxis was then made for five minutes, and failed. Immediately upon failure of taxis a long incision was made over the inguinal canal and tumor and carried down through the tissues until a thin-walled sac was freely exposed. This was also incised, and four ounces of brownish serum escaped, disclosing a web of congested omentum and about four inches of small intestine. The omentum was inky black, the intestine not quite so much injected. A very small and tight constriction was found at the internal ring. This was divided by a Cooper hernia knife with considerable difficulty, incident to the high location of the ring and to the intense constriction—bowel as well as sac overlapping on all sides. A small rent in the serous covering of the bowel resulted, but was immediately repaired with a half dozen Lembert sutures. I have since learned to cut the ring from above in all difficult cases, and thus to avoid the risks of wounding the bowel or other structures passing through the ring. As a division of the ring and roof of the canal from above is now an established procedure when making radical cures for hernia in this situation, division of the ring from below may go entirely out of fashion excepting in desperate cases or in those of the very aged or feeble, where radical operations must be ruled out owing to the increased danger to life inseparable from prolonged operative manipulations.

So soon as the constriction was relieved the bowel and omentum at once resumed their normal color and circulation. The omentum was ligated off in portions and the stump returned to the abdominal cavity. More intestine was then pulled down, as usual, but no further constriction found, and it was also returned to the cavity.

In the sac wall at the position of the external abdominal ring was found undeveloped undescended testicle about half an inch long and three-eighths of an inch wide. This was dissected out with a portion of the sac, the pedicle securely ligated, the testicle cut away, and the stump

returned to the peritoneal cavity. It could have been reduced with the sac, but could not have been returned to the scrotum with a cord manufactured out of a portion of the sac-wall including the testicular vessels and vas deferens. When I considered the uselessness of the organ in its undeveloped condition, its well-known propensity to degenerations and other diseased conditions, and, moreover, as I had secured his consent to its removal, and could make so much better a radical operation with no structure traversing the rings or inguinal canal, it appeared more than justifiable to sacrifice the organ, especially as its fellow was in a perfect condition. The sac (containing the pedicle of the cord) was next dissected free from its surroundings up to and a little within the internal ring. Here it was puckered up after the method of Macewen with a thread and needle and fixed just behind the internal ring, to act as a pad to protect that region from the possible return of a portion of gut. The internal ring and inguinal canal were then completely obliterated by silk sutures and the skin likewise, sutured by silkworm-gut. No drainage was employed. His bowels were moved by fractional doses of calomel and podophyllin within twenty-four hours, and in three days he was eating semi solid diet. The wound healed throughout by primary union. He was kept upon his back for three weeks and resumed his occupation in five weeks. No truss was prescribed.

I have seen this patient recently,—almost one year since the operation—and found the cicatrix sound, with no sign of return of hernia.

## AN OBSERVATION OF THE EFFECTS OF ERYSIPELAS ON EPITHELIAL CANCER.*

JAMES COLLINS, M. D., PHILADELPHIA.

About eighteen months ago my attention was called by Mr. M. to on ulcer nearly opposite the ear, on his right cheek. This ulcer was one and a half inches in longest diameter, one inch in the shorter, presenting an oval with irregular edges. The discharge was slightly purulent, tinged with blood. The granulations were soft and bled on the slightest touch.

Mr. M. stated that twenty years ago there appeared at this point a small elevation, which frequently formed a scab, which every ten or twelve days would fall off and then re-form, giving but little trouble received but little treatment.

Nineteen years ago he was treated for a time with ointments and lotions, also some medicine was administered without special benefit. He was then assured that this was skin cancer and incurable. This ulcer gradually increased in size and depth. Some benefit was derived from a lotion of zinc sulphate and salt, dissolved in water to make a mild astringent solution. The ulceration, however, continued giving inconsiderable pain, but much annoyance by it presence. The good man quietly accepted the situation, seeking only palliation and relief from pain.

About November 12th he suffered from an attack of erysipelas of the face. This ran no unusual course, spreading rapidly from tip of nose over scalp to nape of neck. The efflorescence was followed by desquamation. The external dressing was of ichthyol and lanolin, which seemed to give relief and comfort.

As the erysipelas fadded out, the desquamation following the ulcer seemed to assume a more healthy appearance. Granulations of a more normal character developed and in about two weeks the ulcer was entirely healed. The cicatrix on March 1st is slightly indurated, but smooth and firm, presenting the appearance of normal cicatrical tissue.

This case is reported without special comment. Dr. Coley, of New York, has written on this subject with considerable interest.

The writer is well aware that a single case from the practice of a surgeon is but of little value, isolated and alone, but hoping that others may add their experience and observation the case is reported for consideration.

* Read before Philadelphia Academy of Surgery, March 5, 1894.

# VERBAL REPORT OF THREE CASES OF LEFT INGUINAL COLOTOMY.*

JOHN H. PACKARD, M. D., PHILA.

By some surgical writers, notably the elder Gross, the opinion had been expressed that the making of an artificial anus by opening the colon placed the patient in a condition so distressing that death itself would be preferable. My own experience with these operations warrants me in upholding a very different view. My first case occurred in 1873, and I had the advantage of the presence and assistance of Prof. Gross and of Dr. Levis; the patient, whose rectum was occluded by a uterine cancer, lived in comfort for eight months, dying then from exhaustion due to the advance of the disease. In this instance, and in other cases for many years afterward, I made the opening in the left loin, thinking the access more ready, and preferring to avoid encroaching upon the peritoneum. There is, however, one great objection to the method, that the point of exit for the feces is so placed as to be only with difficulty reached by the patient, and to require the assistance of others in attending to it.

For the operation in the left groin, I think the best rule as to the incision is to make it just as on the right side in appendicitis, an inch and a half from the left anterior superior iliac spine, and at right angles with a line between this process and the umbilicus. With scrupulous asepsis the opening of the peritoneum is made with safety; the operation is one of no more difficulty than that in the loin, and the artificial anus is entirely under the patient's control. The directions given in some of the books for the finding of the bowel seem to me to be needlessly complex; if the large intestine does not immediately present itself in the wound, a portion of the small intestine will, and must be pushed aside, when the sigmoid flexure, especially if distended, will be seen, and may be recognized by the longitudinal muscular bands.

My own opinion is that it is a matter of but little moment whether the bowel is opened at once or after the lapse of several days.

I do think it important that the gut should be well drawn down into the wound until the portion above this point is slightly tense, so as to avoid subsequent prolapse through the artificial anus. Even with this precaution it sometimes happens that the inner wall will pouch out and be a cause of some annoyance.

For suturing the edges of the peritoneum to those of the skin it is well to use black silk, so that these stitches may be readily distinguished from those by which the bowel itself is fastened in the wound; these latter should be of white silk, and should penetrate beyond the muscular coat, but not through the mucous membrane.

It is not always easy to judge how large an opening should be made into the bowel. In a child, or when the wall of the gut is very thin, a small orifice will suffice; and I do not think more than three-quarters of an inch is ever necessary.

CASE I.—James Brewster, a mulatto, aged fifty-five years, but looking much older, was admitted into my ward at the Pennsylvania Hospital, November 26, 1892, on account of epithelial cancer of the rectum. His condition was most deplorable; there was a mass of disease stiffening the wall of the bowel and discharging from its ulcerated surface a very offensive pus, which, mixed with fecal matter, flowed away constantly through the wide-open anal orifice. Hence he not only suffered agonizing pain, but the intolerable fetor made him loathsome to himself as to all about him.

He had, moreover, a left inguinal hernia, which he ascribed to the kick of a horse in January, 1891. This did not in any way interefere with the operation, which was done four days after his admission. The opening into the bowel was not made until December 4th, or four days later.

Immediately after the operation his temperature fell to 97.6°, but he soon rallied and did well. The artificial anus gave no trouble, but was cleansed once daily. By means of washing out with solution of potassium permanganate or other detergents, the rectum was rendered inoffensive. A portion of the diseased

*Read before Philadelphia Academy of Surgery, March 5, 1894.

mass was curetted away about four weeks after the colotomy, but no more radical procedure seemed to be justified.

The patient lived in comfort until April 18th, nearly five months, and then died painlessly from exhaustion.

At the autopsy it was found that the morbid growth extended five inches above the anus, and had involved the posterior wall of the bladder; there were abundant deposits in the pelvic and mesenteric glands.

A somewhat noticeable fact was that the serous covering of the gut was adherent to the parietal peritoneum for a long distance above the point of operation.

CASE II.—Ellen Black, aged fifty-two years, was admitted under my care in the Pennsylvania Hospital, October 24, 1893, suffering from extenisve cancerous disease of the uterus, involving the rectum; she had not had a natural stool for a year. Her general health was not greatly impaired, but she had great distress by reason of the rectal obstruction.

The next day I exposed and secured the sigmoid flexure, and twenty-four hours afterward opened the bowel. Just after the operation her temperature feel to 96. 2°, but reaction took place quickly. Regular movements were soon had through the artificial anus, and on the seventeenth day she was discharged at her own request, to return to her home in Sullivan Co., Pa.

CASE III.—Mrs. M., aged about fifty, living in one of the cities in the interior of this State, was seen by me in April, 1893, on account of almost total obstruction of the rectum by the pressure of a tumor of the womb, which filled up the entire pelvic cavity. To attack this in its then condition seemed to me, as well as to her physicians, unwarrantable; and as her suffering arose mainly from the rectal obstruction, I proposed opening the bowel in the left groin. To this she agreed, and I performed the operation at her residence. Complete relief was afforded, and after some experiments in the devising of a suitable contrivance for keeping control of the contents of the bowel, this lady was enabled to resume her active life, going into society freely, and attending to all her affairs without hindrance.

Should this tumor, probably a fibroid, develop so as to rise out of the pelvis, the question of hysterectomy might be entertained; and if this were successfully accomplished the closure of the artificial anus might, perhaps, be undertaken.

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### THERAPEUTIC ACTION OF ALPHA-NAPHTHOL.

Dr. Maximovicz (*Wiener Med. Presse*, No. 10, 1894) has studied the physiological and therapeutic action of alpha-naphthol and finds that it is three times as powerful a bactericide and far less toxic than the beta-naphthol. In typhoid fever he usually administers it in doses of 0.50–1.0, three to four times a day; if this be insufficient he increases it to 6–8 gms. Under the influence of the drug the morning remissions are less pronounced, the tongue clears up, the meteorism and the pains in the right iliac fossa decrease and finally disappear. The duration of the disease is markedly shortened. It must be continued until the temperature has remained normal for three to four days. The formulæ are as follows:

℞

| | | | |
|---|---|---|---|
| Alpha-Naphthol | .050—0 | 75 | (grs. —viij-xij). |
| Bismuth Salicylate | 0 | 30 | ( " v). |
| Powd. Cinnamon | 0 | 20 | ( " ij). |

For one powder. Make twenty such. Four to six powders, per diem.

If there be great meteorism with violent abdominal pains than use:

℞

| | | | |
|---|---|---|---|
| Alpha-Naphthol | 0 | 50 | (grs. viij). |
| Bismuth Salicylate | 0 | 30 | ( " v). |
| Powdered Rhubarb | 0 | 20 | ( " ij). |
| Extr. Belladonna | 0 | 01 | ( " 1-6). |

For one powder. Make twenty such. Four to six powders a day.

Or,

℞

| | | | |
|---|---|---|---|
| Alpha-Naphthol | 0 | 50 | (grs. viij). |
| Codeine | 0 | 01 | (gr. 1-6). |
| Powdered Rhubarb | 0 | 10 | (grs. jss). |
| Powdered Cinnamon | 0 | 20 | ( " ij). |

For one powder. Make twenty such. Four to six powders a day.

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

In dysentery he has had very good results with alpha-naphthol and castor oil:

℞ Alpha-Naphthol 1.0 | 4.0 (grs. xv-℥j).
Castor Oil..... 100 | (℥iijss).

From a coffee to a tablespoonful several times a day.

In the grippe he employs the following combination:

℞ Alpha-Naphthol.....0 | 50 (grs. viij).
Calcined magnesia.....0 | 20 (grs. ij).
Phenacetine.....0 | 30 (grs. v.)

For one powder. Make twenty such. Four to six a day.

In pulmonary tuberculosis with disturbance of the intestinal functions and profuse night sweats he prescribes, with good results, the following pill:

℞ Beechwood Creasote.
Alpha-Naphthol,..... āā·8 | 0 (℥ij).
Arsenious Acid.....0 | 12(.grs. ij).
Strychnine Nitrate,..... 0 | 05 (grs. ¾).
Atropine Sulphate ..... 0 | 01 (grs. 1-6).
Extr. Gentian.
Gum Arabic. āā. ad 120 pills.

Four to six pills a day.

In erysipelas, small-pox and other skin diseases he has employed a solution of the drug in olive oil, with good effect:

℞ Alpha-Naphthol,..... 0 | 10-30 (grs. jss-v).
Olive Oil.....100 | (℥iijss).

For external use.

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### COTTON-ROOT AS A HEMOSTATIC IN MENORRHAGIA.

Dr. Poteyenko (*Revista De Ciencias Medicas de Barcelona*, No. 4, 1894) having his attention called to the value of the extract of cotton-root as a hemostatic, in a case of uterine hemorrhage, has employed it as a hemostatic in various forms of hemorrhage. In all he had prescribed it in fifty-nine cases, administering the extract in doses of twenty to thirty drops, three to four times a day; the curative effects are generally noticeable on the first or second day of its administration, even when other hemostatics have been used in vain. The most notable case was that of a man of twenty-five years, who, in good health and well nourished, had suffered from daily attacks of epistaxis for over three months, for which he had consulted several physicians. On examination of the nose only a hyperemic state of the mucous membrane was to be observed. Ergotine, Hydrastis Canadensis, Fowler's solution and locally, solutions of tannin, boric acid, etc., were prescribed. No result being obtained he administered the fluid extract of cotton root, Gossypium herbaceum, twenty-five drops three times a day. The patient did not return and when accidentally met a week later, he said that after taking the remedy for three days the epistaxis did not reappear. For a whole year since he has been free from the hemorrhages. From his cases and observations he concludes that cotton-root is an efficacious, inoffensive and quite certain hemostatic, which not only does not disturb, but on the contrary, assists digestion. It may be employed in the treatment of metrorrhagia during pregnancy; it reduces the hyperemia of the mucous membranes. It is not necessary to go over above thirty drops at a dose.

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### TREATMENT OF ECZEMA OF THE EYE-LIDS.

Dr. Trousseau (*Revue Intérnationale de Bibliographie Medicale, etc.*, No. 2, 1894) has obtained unexpected results in this obstinate affection with local applications of a solution, without alcohol, of corrosive sublimate—.05-.25 gms. (one to four grains) to five hundred grams (sixteen ounces of water.) Compresses soaked in this fluid are also employed. He has observed remarkably prompt results after the ordinary means had failed. Internally, one may give quinine, and, locally employ a solution of carbolic acid to allay the itching. Salves are contraindicated as they are not well borne and sometimes cause the affection to become aggravated; they are, however, to be used in the terminal period when desquamation of epithelium sets in and then only, with caution; first trying those least irritating as pure vaseline or lard, then bismuth, oxide of zinc, ichthyol, yellow oxide of mercury or oil of cade.

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JUDGE KELLEN was for many years police judge of St. Louis. An old Irishwoman named O'—was often before him in consequence of her great fondness for "a drap of the cratur." One Monday morning she was called up, and the clerk read the charge: "Mary O'—found drunk in the street."

"Well, your honor," said Mary, "I'll not be pl'adin' at all to that charge: it's too gineral. It don't say what strate."—*Green Bag.*

# THE MEDICAL AND SURGICAL REPORTER

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SATURDAY, APRIL 28, 1894.

## EDITORIAL.

### A STUDY OF HYPNOTISM.

When positive benefit derived is made the sole justification for the use of a procedure otherwise unrighteous and even dangerous, its therapeutic value most be proven beyond peradventure before the medical profession can make its application general.

The decision must be based on the evidence of witnesses whose experience and training are such as to make their testimony credible and without prejudice. In this connection we rehearse the conclusions of Professor Benedikt, of Vienna, who has recently published a critical essay on "hypnotism," which is the most important contribution to the subject that has appeared of late. The writer is an authority on diseases, and enjoys the reputation of being a fearless, but impartial and careful investigator. His experience of hypnotism dates from 1870, when he made his first experiments, ten years before the present revival began in France, and since then he has studied every phase of it with an open, but keenly critical mind. His main conclusion can be summed up in a few words—hypnotism is real, but practically no good. This was precisely Charcot's conclusion, and it is that of most clear-headed and honest observers. It is the mean between the two extremes, held on the one side by those who deny the facts and ascribe them to imposture or bad observation, and on the other by those who claim to have discovered in them a new and powerful means of treating disease.

Benedikt is fully alive to the extreme liability to imposture and deception involved in these experiments, and points out with great force how and why this occurs; but, as he pertinently observes, it is utterly illogical to deny the original fact because it may be imitated. "Otherwise one must maintain that there are no genuine emotions, no genuine madness, and no genuine dying, because they can all be artificially imitated in such a masterly and deceptive manner."

He has the most utter distrust of all professional subjects or mediums, as he calls them, who are just as useless for disproving as for proving supposed facts, because they have got into such a state that they do not know themselves where reality ends and imposture begins, and will say or do

whatever they believe is expected of them, even to confessing imposture, whether it has occurred or not. Benedikt is, both by nature and training, particularly on his guard against deception and equally competent to detect it. "Hypnotic experiments," he says, "without objective proof, cannot in general be used as facts having the value of scientific evidence." Further, "only experiments carried out on disinterested individuals unversed in the mysteries of hypnosis have any value." In this guarded attitude, he unhesitatingly adds his testimony to that of other distinguished observers as to the reality of the hypnotic condition.

Apropos of the reality of the mesmeric condition, the following incident is related by Professor Benedikt: At the Anthropological Congress, held in Paris in 1878, Virchow asked Benedikt to introduce him to Charcot, who had then recently taken up the study of mesmerism; and they all three visited the latter's clinique. Here Charcot showed them his famous cases of "grand hysteria," and demonstrated his method of conducting the patient from one phase of the attack to another. "Surprised and astonished as Virchow was, we were both completely convinced, as completely as Charcot himself, that we were dealing with indubitable facts. I must admit feeling a certain malicious pleasure in getting Virchow to recognize these experiments, which were certainly connected in some degree with animal magnetism."

As a method of treatment Benedikt condemns it emphatically, while admitting that it possesses a certain therapeutic action, which may, perhaps, be applied with benefit here and there in a rare and exceptional case when everything else has failed. Systematic hypnotism is not only useless, but actively injurious, as it has a "demoralizing influence on the intellect, the will, and the psychical independence of the subject;" it may relieve for a moment, but eventually lowers the organism like narcotics; it is even "an offence against the security of life." This opinion is derived from experience, as it was with Charcot; but it is supported by reason and common sense. A hypnotic patient is like a rider with a bad seat, who cannot keep his equilibrium, and falls off his horse. Holding him on by a strong hand is all very well for the moment, but it leaves him more helpless than before. So with the hypnotic subject who has a weak mental balance, artificial support by "suggestion" only increases his damnation.

He would abolish the term hypnotism—surely one of the most foolish ever invented—altogether, and use mesmerism instead, or "artificial catalepsy." The latter is open to the serious objection that it already has another and a different meaning; but mesmerism is unexceptionable. It commits to no theory, and was commonly in use when all the supposed new discoveries were made half a century ago.

Professor Benedikt does not indulge in much theorizing about the nature of the mesmeric state, but he believes that it depends on some form of artificially produced tension and relaxation, and he thinks that the problem will be solved—in part, at least—when we have a proper instrument for measuring "bio-mechanical tensions." "Whether it will be constructed on the electrical, the magnetic, the chemical, or some other hitherto unknown principle, I do not know. But the facts, long ago put forward by Mesmer in classical style, point to polar opposites; and those of transference, etc., show conclusively that we have to deal with processes of tension and relaxation."

From the foregoing passage, it is clear that he considers the theory that mesmerism is purely "subjective" to be nonsense. And, indeed, those who maintain it either do not know the meaning of the word subjective or are ignorant of the facts.

With regard to the transmission of impulses without contact, which has been airily dismissed by some authorities, he declines to decide whether it is effected by direct action or only through the imagination; "although," he adds significantly, "I have seen Hansen produce startling effects on individuals known to me and studied by me, and I have myself often observed its operation in cases which were as free as possible from objection."

In conclusion, he thinks the greatest practical service rendered by the modern revival of mesmerism has been to draw the attention of physiologists to the initmate relations between the mind and the body.

## ABSTRACTS.

### "BASE INGRATITUDE."

Suits for malpractice against physicians have grown to an alarming extent in the last few years in this city. We understand that nine suits are now entered on the dockets of the various courts, and the damages claimed vary from ten to seventy thousand dollars in each individual case. One suit which was recently disposed of is about the history of all of them. After the physician had done all in his power to alleviate a blind man (charity patient), he was rewarded for his pains by having a suit for malpractice instituted against him for twenty-five thousand dollars damage.

The suit was that of H. L. Hershey against Dr. L. Webster Fox. The action was brought to recover damages for the loss of an eye after a needle operation for secondary cataract. In 1883, Dr. Fox removed a cataract from the left eye of this patient; two years subsequently a needle-operation was performed, and vision restored. In 1888 a cataract was removed from the right eye successfully; two years later this was followed by a needle-operation on the capsule, which obscured the vision in this eye; ten days after the operation inflammation developed, eye lost.

There were several important points brought out in the trial which are well worth preserving in the minds of surgeons:

*First.* It remains with the plaintiff to prove that carelessness and want of skill and due diligence were manifested on the part of the attending physician.

*Second.* It is not absolutely necessary for the physician to inform or explain to the patient the character of the operation to be performed.

*Third.* That the physician is not responsible for the results of an operation, so long as he uses a reasonable amount of skill and care.

The medical profession requires the highest skill, constant study, and unselfish devotion to the interest of mankind, and the medical man should be above the sordid acquisition of wealth. His motive for the pursuit of his chosen profession must come from his heart; but when one meets with such "base ingratitude" as these nine physicians are receiving at the hands of unmitigated scoundrels or blackmailers, it is enough to chill the softer feelings within themselves and make Shylocks of them all. With all due respect to those Nestors in the profession who constantly preach that the practice of medicine must be conducted on humane lines, and not by business methods, we say, that the students of medicine and the younger practitioners must realize and accept the fact that that day is passing away. When business methods prevail, then we shall not have suits of malpractice hanging over us to annoy, consume our time, and abstract tribute for defense; for such suits only come from those for whom we have given time, mental anxiety, even money out of pocket; our compensation—nothing. The unprecedented remarks made by one of our most honored judges, in granting a nonsuit in Dr. Fox's case, are well worthy of being repeated.

Judge Biddle said: "I do not see the slightest evidence in this case of any malpractice whatever. This man was attended for eight years, and a most serious operation performed upon him (and he paid the doctor ten dollars, which was paid the optician for glasses), in addition to attending his wife and giving him prescriptions for other matters. I think it is a case of *base ingratitude* for the services that were rendered. I grant a nonsuit."
—*Med. Bul.*

## DIETARY IN TYPHOID FEVER.

Dr. W. H. B. Aikins, (*Dominion Medical Monthly*) says:—

As I understand it, the cardinal principles of treatment in enteric fever are: (1) By free action of the bowels to remove all ptomaines and offensive materials. (2) By careful dietary to conserve the patient's strength. (3) By cautious use of antiseptics to keep the alimentary canal in as aspetic a condition as possible, and in a rational and conservative manner to treat symptoms and complications as they arise.

When the patient first comes under my care, it has been my custom to prescribe calomel in small doses in the evening and follow this up by a seidlitz powder in the morning in order to have a free alvine evacuation. If one seidlitz powder is not sufficient, a second one may be given two hours later. The patients are not purged, but it is well that there should be a free movement every second day at least, throughout the illness. I have found calomel the most satisfactory drug on account of its stimulating the flow of bile, thus assisting in making the contents of the alimentary canal aseptic; but it must be used with caution in anæmic cases.

Prior to the time of Graves and Trousseau enteric cases were sadly underfed, and though these eminent men ardently advocated a sufficient supply of nutriment, it was always nourishment in the liquid form. To quote Trosseau's words, "I am convinced that the starving system has in many cases been carried to dangerous excess, that many persons have fallen victims to prolonged abstinence in fevers," while Graves said to his pupils, "If you are at a loss to find an epitaph to inscribe on my tomb, you may use these words—'he fed fevers.'"

We find that Sir William Jenner, in an address at Birmingham, in 1879, stated that, "From the first the patients should be restricted to liquid diet with farinaceous food and bread in some form, if the appetite require it. The value of milk as an article of diet in fever, is generally admitted, but it requires to be given with caution."

Strümpell allows broth and soup thickened with sago or rice, and a role of rusk when softened by soaking. Briefly then it is seen that by rapid stages the dietary has advanced from water soup to thickened soup and a little bread.

In the journal of the American Medical Association of the 10th of February, I noticed that a gentleman reports a case of typhoid fever with a favorable termination as follows: "Diagnosis typhoid fever. Diet—ate beefteak on the seventh and eighth days of treatment, milk diet on the ninth, and solid therafter." And there is one prominent New York physician who is so generous as to allow when the patient so desires, a mutton chop, with potatoes and beer.

This, however, is, according to my view, carrying the matter to dangerous extremes.

The dietary which I have found most satisfactory and which has been allowed to my last thirty five cases of enteric fever in private and hospital practice, has been almost uniformly the same, but governed by the feelings and wishes of the patient to a certain extent.

For breakfast, if desired by the patient, a lightly boiled, scrambled, or proached egg, with a little bread and butter, milk in quantities agreeable to the patient with broths clear or thickened, such as oyster, chicken, mutton or vegetable. At intervals during the day a choice of bread and butter, bread with meat gravy, strained rice or sago pudding, custard, junket, milk toast, oysters, or biscuit with a little wine. Patients are not given more than two eggs and eight ounces of bread in the twenty-four hours.

The thirst may be quenched with pure spring water or pure mineral waters. Various other fluids are also allowed, such as barley water, egg albumen water, lemonade, koumiss, buttermilk, cocoa, tea and coffee.

This diet has not in any of my cases unfavorably influenced the temperature or prolonged the duration of its elevation, and it may be given at any stage of the disease.

The results have been uniformly satisfactory. When on the dietary the patients appear more contented. There is less tendency to nausea and gastric disturbances, less tympanites, and the diet being mixed and somewhat the same as used in health, the bowels are much less constipated than when patients are nourished on milk alone.

# SOCIETY REPORTS.

## THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

*March 28th, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

Dr. Wallin of New York read, by invitation, a paper on

THE TREATMENT OF SCOLIOSIS, AND THE BRANDT METHOD OF MASSAGE.

(See Page 598).

DISCUSSION.

DR. CLARA MARSHALL: I was struck with one point in the paper, that is that it was not only a description of a method, but to a certain extent a defence of a case. I think that all who write upon this subject place themselves somewhat in an attitude of defence, as Brandt not being a physician, has been so often attacked as being dishonest. Anyone who has read the introduction to his book will be thoroughly convinced to the contrary. He tells in a straightforward way of his interest in the method. His first case was one of prolapsus ani in a man. He tried "lifting" through the abdomen and cured the case. The next case was one of prolapse of the uterus. I would ask Dr. Wallin to give the date of the treatment of this case, which is of great interest on account of the length of time that the cure has lasted. Having cured these cases he was emboldened to treated other cases, and so he was gradually led to success. He says himself that he believes that this method should be in the hands of physicians, and that if doctors will not others must, in order to relieve suffering.

DR. R. FLEISHER: I may speak of the work of Professor Ziegenspeck (Germany) in whose clinic I saw massage used for a number of months. He had very excellent results in chronic inflammatory troubles, and in private practice his results have been very good. Throughout, the treatment requires to be continued so long that it is almost impossible to induce the patient to come to the office or dispensary with sufficient regularity to carry out the treatment properly. The cases that I saw treated in private hospitals did excellently.

DR. J. MADISON TAYLOR: While I am not in any sense a gynecologist, I think that it is only right for me to say a word with reference to this subject of massage. In pursuing some researches in massage I have gone into this question from a literary standpoint, and I think there is ample evidence to prove that this method is of great value if properly pursued. I think that if those gentleman who know all about gynecology from their standpoint would give some attention to this method it would be to the advantage of their patients. There is considerable evidence to prove that those slow, non-American methods by manipulative procedure do a great deal of good in displacements of the uterus as well as in displacements of other portions of the anatomy. There have been very brilliant results which cannot be impugned, and of which we should have some evidence in this country if the method were properly taught and demonstrated.

DR. BENJAMIN LEE sent the following letter:

PHILADELPHIA, MARCH 27, 1894,
1532 Pine Street.

DR. JAMES K. YOUNG,
*Chairman Directors Philadelphia County Medical Society.*

DEAR DOCTOR: Since accepting your kind invitation to take part in the discussion tomorrow night I have been unexpectedly called away, and fear that I shall not be able to return in time to be present. I regret this very much, as I have no doubt the occasion would prove of especial interest to me. I desire to say, however, that I have never been able to bring myself to look with favor on intravaginal massage of the uterus and its appendages. I believe, in the first place, that a judicious combination of abdominal massage, with carefully selected localized movements of the lower extremities and inferior portion of the trunk, will accomplish as much, in the great majority of cases, as internal massage; and, in the second, that, for reasons that will at once suggest themselves, manipulation of the vulva, and the frequent introduction and prolonged retention of the fingers or hand, even of a woman, into the vagina is a practice to be deprecated. The possible relief to be obtained might be bought at too high a price.

Yours, very truly,
BENJ. LEE.

DR. M. PRICE: I agree with Dr. Lee most heartily, that no matter how much good might be accomplished, it would not compensate for the damage and the injury done by the Brandt method of massage of the uterus and vagina. This method would not break up adhesions which you find difficult to release, even with your fingers, with the

abdomen opened. Again, there is no question that vaginal manipulation even in the hands of women upon the young and undeveloped female must of necessity educate to habits of immorality. We all know the evils of self-manipulation. I do not care who is the woman or man who carries out this treatment, it is wrong, and wrong in its very inception.

Reference has been made to the cure of prolapse by this method. This I do not doubt. If the patient is put in the knee-chest position, and the uterus handled for any length of time, it will be replaced. We have all seen cases relieved by putting the patient to bed and reducing the weight and the congestion of the uterus by position and rest.

We must certainly condemn anything in the way of unnecessary manipulation in the vagina for any purpose. In all our examinations we avoid all irritation and unnecessary handling. A few years ago a member of this Society recommended the examination of women during pregnancy to correct malposition of the child, but it was generally denounced by the best members of the Society as wrong in every way.

In most cases prolapse is due to laceration of the vagina, so that there is no support to the pelvic viscera. We cannot expect to cause the ends of the torn muscle to unite by manipulation. We cannot restore what does not exist.

DR. GEORGE E. SHOEMAKER: I have seen enough of this method to feel convinced that it has a certain field which might well be cultivated. At the same time I feel that among American women the field is not as great as among the women of some more phlegmatic races. If this method is developed in this country, it should be in the hands of women physicians, and in the hands of a very few. These should be experts whom we could trust. I do not believe that it can be largely adopted by the medical profession with advantage.

DR. FRANK WOODBURY: The reference to ovarian massage recalls to mind the fact that some years ago some foreign authority recommended the treatment of hysteria by making forcible pressure on the ovaries. It occurs to me that this may be a favorable occasion to inquire into the possible bad results which may follow such treatment. During the menstrual life of a woman there are always Graafian follicles ready to rupture, and this is usually associated with more or less hemorrhage. Might such massage of the ovaries lead to localized or general peritonitis, or some other undesirable consequence?

DR. WALLIN, New York: In reply to Dr. Marshall I would state that I think the man with prolapse of the anus was treated in 1847. It was in 1861 that Brandt treated the first woman for prolapsus. He used only external manipulation, consisting of lifting, abduction of the knees, and tapotement over the sacrum. Twenty years afterward I saw the woman, who was then sixty years of age, and there never had been any return of the trouble. In Sweden the peasant women do a great deal of heavy work, and consequently prolapsus of the uterus is very common, even where there has not been laceration. None of the cases referred to have been treated in the knee-chest position. I have seen a number of cases treated by Brandt, and every one that he has undertaken has been benefited.

With regard to massage of the ovaries: the massage is always very light, and is generally given in peri-oöphoritis. You cant improve oöphoritis very much. All massage is given after the inflammatory condition has disappeared, especially if it is purulent.

As to the immortality of the treatment, I do not know what to say. The same objection would apply to all gynecological treatment. I have never heard this objection raised before, and, as I say, it would equally apply to all examinations.

DR. RANDOLPH FARIES: We know that the rotatory movement of the spine is first produced by muscular action, while the lateral curvature is a secondary effect. It is also known that each side of the body is made up of the same group of muscles functionally, and that logically to get rid of the deformity we must use the muscles which act as antagonistic to those producing the deformity. Hence it seems to me the first thing to do is to unrotate the bodies of the vertebræ, because rotation was the first thing that took place. Then correct the lateral curvature. Further, the muscles act as pulleys and levers; but there is no book giving us the compound action of muscles, and we have no means of studying the resultant of the forces if we elevate and rotate the body at the same time. Spinal curvatures are produced by compound forces, and in order to get at the true treatment requires a knowledge of mechanics, not a knowledge of medicine, hence it seems to me this is a line for good scientific study.

I have seen it stated that one cannot do much for spinal curvature after it has gone pretty far. We are pretty sure that we can do something, for the skeleton is not converted into bone until the age of twenty years, and the majority of cases present themselves between ten and fourteen years of age. Why can we not unrotate the spine in a rational way by compound movements, and thus correct the deformity?

DR. H. AUGUSTUS WILSON: Dr. Wallin has introduced a profoundly interesting subject. In reference to the plan of treatment which has been described we must consider whether it alone is curative, or whether it

must be applied in association with other remedial measures. Myotomy of the over-acting muscles has been advocated, and following this prolonged recumbency has been employed in the endeavor to obtain corelation. Adams introduced the prolonged recumbent position with the same object. Sayre used the plaster-of-Paris jacket for the same end. The object of all these methods has been to diminish the power of the over-acting muscles. This attempt to introduce a system of gymnastics has been carefully studied by Ling and other investigators, and comes to us in a practical form, but with a number or serious obstacles. Among these obstacles may be mentioned the preconceived idea that gymnastics mean a more or less large amount of cumbersome apparatus. Another objection is that a skilled attendant must be present at the time of the manipulation. One of the most serious objections is that often the method is not considered worthy of that same careful study that other therapeutic measures are, and therefore the method is left in the hands of incompetent persons. Another obstacle is the idea that if the exercise is taken once or twice a week it is ample for all purposes.

I think that the most important part of remedial gymnastics lies in the instruction of the patient in such a way that she may apply in her own home exercise that will be curative. I do not know of any class of patients who can be induced to keep up remedial gymnastics where there is the monotony of chest weights and apparatus. The patient must be taught that she can do it herself if we are to expect improvement. I have followed out these cases for a number of years, and can safely say that the only cases of scoliosis that have been cured have been relieved by gymnastic measures. The apparatus has been taken off, and the muscles and the whole system developed, and as a result they have become nearly straight. Where the patient can afford the attentions of a manipulator, it is far more satisfactory in every way, for there are cases where you cannot instruct the patient to do as you want. The methods in which the movements were to be made were demonstrated on a patient brought for that purpose.

DR. JAMES K. YOUNG: We recognize three degrees of scoliosis—the mild, the medium, and the severe. These can be distinguished by suspending the patient. If the curve entirely disappears, it is of the mild form. If it partially disappears, it is of the medium form; and if no effect is evident, it is of the severe form, in which nothing can be accomplished by massage and exercise. There are six varieties according to the position. The most common form is right dorsal scoliosis; the second is left lumbar; the third, left dorsal; the fourth, right lumbar; the fifth, right cervical; and the sixth, left cervical scoliosis.

In the mildest form a cure can be confidently promised. In the medium form a cure cannot be promised, although great improvement can occur. It is more important to direct the different forms of exercise than to conduct them personally, and to do this one must command considerable anatomical knowledge. When a person makes a movement so many muscles are thrown into action that it is almost impossible to describe them all. The attempt was made by Dr. Keating and myself to describe the muscles brought into action in the different Swedish movements. There are about three hundred different movements. We analyzed about thirty in the article upon "Physical Development" in the *Cyclopædia of the Diseases of Children.* We also obtained eight different combinations of these movements which would furnish exercise for every muscle in the body.

In the treatment of these cases it is necessary first to develop the system generally, and afterward to treat the lateral or other deformity. The principle in all Swedish movements is to develop the muscles on the convex side of the curve. I would particularly call attention to the development of the muscles about the pelvis, especially the lateral and adductor muscles. In the cure of scoliosis it is necessary to have the pelvis straight. In many of these cases there is tilting of the pelvis. The pelvis must be accurately balanced, and for this reason many of the movements are directed toward the development of the muscles about the pelvis. By carrying out these movements the mildest cases can be positively cured, while many of the medium cases can be much benefited.

DR. WALLIN: I always teach the patient some movements to be carried out at home. I have to-night shown only a few of the movements that are intended to affect the curves. The best results I saw were obtained by using "self-correcting" movements, at Dr. Tidemand's Orthopædic Institute. Cases of the first degree are always cured, and where no improvement occurs the patients learn to carry themselves that the deformity does not show to a marked extent.

---

Smith and Jones had been joking each other. Said Smith—"You can't get a sell on me, no use to try."

Said Jones—"Which hand do you feed your hens with?"

Smith replied—"With my right hand."

Said Jones—"Most people feed their hens with grain, and when they feed meat usually choose that of some other animal."
—*Boston Courier.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

ARCHIVES OF PEDIATRICS

for April. Dr. J. W. Ballantyne writes of

**Congenital Ichthyosis,**

stating that his object is to show the existence of a connecting link between ichthyosis of the adult and ichthyosis of the fœtus (cases that were born with a predisposition to the disease, although no manifestations may have occured for weeks.)

Of fœtal ichthyosis there are two varieties; the grave, developed probably at the fourth month of gestation, characterized by deformities or various parts of the body and by the whole body being coated by horny plates separated by furrows, and leading to death in a few hours, or days. The subject of this disease is rarely born dead. No records of either parent suffering from ichthyosis is noted, but frequently several ichythyotic children are born in succession, and a case is noted where three healthy children were borne by a woman who afterward had three ichthyotic ones by another husband.

Respiration was usually interfered with by epidermic masses blocking the nostrils, and suction, by the presence of plates around the mouth.

The appearance of a child with this disease is very repulsive, though it varies by reason of different sizes of plates and furrows, etc. The odor is very unpleasant ("Cadaveric.")

The rigidity of the plates, and the contraction of surrounding parts, is apt to cause ectropion of the eyelids, and a similar distortion of the lips, the limbs are usually kept in the fœtal attitude, aad the digits deformed like birds claws, when present.

The viscera generally show, post mortem, nothing abnormal except an unnsual degree of congestion, and a microscopic examination has shown no extension of the process along any of the mucous surfaces. No record is found of the condition of the thyroid.

The minute examination of this thickening shows that the stratum corneum is the part which hypertrophies, the interpapillary processes in the rete malpighii being elongated, but less thick than nornal, the stratum lucidum is increased in thickness, and no stratum granulosum is to be found.

Now as to the disease just described being simply a severe form of true ichthyosis, the author quotes a case which presented all these appearances, but of course not so fully developed, two days after birth, and who showed true ichthyosis in adult life.

So far as fœtal ichthyosis been hereditary, the fact of no child presenting, when born, the symptoms of ichthyosis, surviving more than a few days, seems to set the question aside; but a family prevalence is well known.

The author regrets the absence of information about thyroid development and states that one case shows improvement under thyroid feeding.

The prognosis is bad, but rectal feeding, softening of the palates by washes, ointments etc., are the means usually tried. The article will be concluded in a later number.

Dr. F. H. Southgate writes on the

**Aetiology of Hernia,**

particularly in reference to rachitis. Race he mentions, the Jews being particularly liable, the Irish almost exempt. Inherited predisposition shows itself often in cases under a year old. Elongated mesentery, incomplete formation of the muscles of the abdominal walls, and relaxation from poor health, straining from bronchitis, whooping cough, crying, phimosis, etc., and at stool.

The muscular and general weakness caused by rickets and deficient peristalsis, leading to distended weak abdominal walls, leads to this disorder much as corpulency does in adults. Some interesting statistics are given confirming the author's theory.

Dr. J. Oscroft Tonsley, giving clinical memoranda about external suppurative periostitis in the region of the ear advises an incision as soon as the diagnosis is made and if possible before pus forms. To avoid arterial injury he feels for the temporal—places his thumb on it, inserts his knife close to it, and cuts back to the mastoid, slips the knife beneath the temporal and freely incises the periosteum finding a very free incision followed by poulticing the only satisfactory treatment.

In the same number an article of Dr. W. W. Myers is quoted (from the Am. Therap.) giving the results of experiments with

**The Toxalbumen of Diphtheria.**

A diphtheria bouillon culture is made, filtered, evaporated to one-third of its bulk, then heated with ten volumes of alcohol and acetic acid. The clear liquid obtained is dialyzed for seventy-two hours, then precipitated with alcohol and dried. The white residue is the diptheria toxalbumen.

A local application of four per cent. solution of this was made in three cases of diphtheria, with recovery. Ten exposed persons were inoculated in the arm and none contracted the disease. Sixteen children exposed to croup (showing Loeffler bacillus) were inoculated in this way, and all escaped.

The symptoms of inoculation were as follows:

The second day a small red pimple, becoming vesicular by the fifth day, then pustular and drying in about three weeks. About the eight day headache, pains in loins, perhaps vomiting. No eruption of any kind, swelling of the axillary lymphatics about the ninth or tenth day. In a few cases appeared swelling of the tonsils, (without membrane) with the appearance of inflammatory sore throat, but no ulcers.

Wm. C. Dabney uses as a prophylactic in diphtheria 1-96 to 1-60 grain of bichloride in a teaspoonful of glycerine every three hours, without water, and no water is used for half an hour.

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BROOKLYN MEDICAL JOURNAL

for April contains an article read by Dr. O.A. Gordon before the Brooklyn Gynæcological Society on

**Asepsis in Obstetrics.**

Thorough cleansing of the hands of the nurse and of the obstetrician, and the genitals of the patient, and the use of bichloride wash at every examination, are the main points of the paper. The author uses a solution of one grain of bichloride to two ounces of glycerine as a lubricant. He mentions a case where the attendant announced that he had just returned from a severe case of diphtheria at the time labor took place, and the infant, then the mother, and finally another child, developed the disease and died from it.

In the discussion which followed it seemed to be the opinion of those speaking that, while a physician might go from a contagious disease to a case of labor, he could do so safely only by the most thoroughly antiseptic precautions and one member thought it safer in such a case to avoid vaginal examination, if possible, and make use of external palpation only.

A difference of opinion was shown in regard to the comparative dangers of sepsis in abortion and in labor, and whether the washing of the liquor amnii was an offset to the enlarged uterus and the greater surface exposed as a result.

Dr. D. W. Barker describes an interdental splint intended to prevent epileptics and others from biting the tongue and lips at night. The apparatus consists of two hard rubber splints enclosing the first lower molar and the bicuspid and passing inward toward the palate—so protecting both tongue and cheeks.

Of course the teeth cannot complete close, with this in use, and, as it fits very firmly and cannot be accidentally dislodged, it has proved very satisfactory. It interferes so much with speech that it cannot be used during the day.

Dr. George Ryerson Fowler reports a case of thrombus of a varix of the saphenous vein simulating irreducible femoral hernia.

The patient had fever—had had rigors, etc. A tumor extending below Pouparts ligament four inches into Scarpa's triangle. No impulse could be felt on coughing, and an operation was done without a very clear idea of the conditions about to be found. The author thinks it very fortunate that the excessive tenderness prevented taxis as that would have probably led to septic embolism. The tumor was excised and proved to be a large saphenous varix obliterated by a clot. The patient recovered without complication of any kind.

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THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY

for April. Dr. J. M. Baldy contributes a paper on

**Conservative Surgery on the Uterine Appendages.**

It would be folly, he says, to formulate any hard and fast rules for the treatment of these patients; each case must be settled on its own merits. But from his experience he has formulated the following:

1. The vast majority of Fallopian tubes, whose canals have been closed by pelvic inflammations, have been rendered useless for all time to come.

There is no way in which we can with any certainty distinguish those few cases in which the tube might be again rendered patulous, and in experimenting in this direction practice has clearly demonstrated that infinite harm may be done as against the little good.

3. It is always well to save healthy ovarian tissue for the sake of the continuance of menstruation and ovulation where this can be safely accomplished.

4. Uncomplicated and small hæmatomata and hydrops folliculi do not, as a rule, give rise to distressing symptoms.

5. It is extremely probable that in the case of the vast majority of uncomplicated ovarian disease upon which so-called conservative surgery has been used, the relief of symptoms has arisen not from the surgery, but from the enforced rest in bed, proper feeding, nursing, and removal from care and worry; the disease being general and not local.

6. Adhesions or prolapse do not necessarily necessitate removal of the uterine appendages.

As a contrast to Dr. Baldy's paper is one by Dr. G. Betton Massey entitled "Certain Erroneous Principles and Methods in Gynæcology" in which the author inveighs against pessaries, gynæcological surgery of all kinds from the repair of a lacerated cervix and abdominal section for the removal of diseased appendages to hysterectomy for fibroids, and asserts that in electricity will be found the cure for most of the ills that female flesh is heir to.

Dr. Franklin Townsend discusses

**Scanty Menstruation.**

He summarizes his paper as follows:

1. Scanty menstruation is most usually the result of malnutrition in both young and middle aged women, married or single.

2. The primary seat of this troubled lies in the condition known as chloro-anaemia.

3. Its treatment must be directed in an intelligent manner towards rectifying this condition. Persistent patience must be persevered in with the various forms of treatment, if a permanent care is to be expected.

In this issue appear two papers on

**Hysterectomy.**

The first is by Dr. I. S. Stone entitled "Hysterectomy for Large Tumors" The author believes that it would be well for operators to have tumors carefully weighed, not estimated, and, in addition a verification of some disinterested person would add to the value of such reports. He believes that tumors will seldom be found to be as reported. He refers to the celebrated cases of Mr. Keith and reports in addition two cases of this own in which the tumors wieghed ten and fifteen pounds after removal. They were removed after Baer's method with recovery in both instances. Photographs of the patients before operation are given.

The second paper is by Dr. R. S. Sutton on "Hysterectomy for Myoma of the Uterus." Within a year, he has used the elastic ligature, pedicle outside; has tied the neck with double ligature, as in ovariotomy, and dropped it; has taken out the entire uterus; has left the neck in, but under the peritoneum, and all of these cases have recovered. His opinion is that no hard and fast rules are wanted; let each case prompt the operator to do his best in his own way. There is no rule of three for good surgery.

Dr. J. C. Irish contributes a paper on

**Appendicitis.**

From his own experience he would divide cases of appendicitis into three classes:

1. Inflammation of the appendix without perforation.

2. Appendicitis with perforation, the septic focus being walled off from the general abdominal cavity by agglutinated coils of intestine and lymph deposit.

3. Appendicitis with perforation not walled off, and in which the general abdominal cavity is invaded with sepsis,—in other words, a diffuse septic peritonitis.

From his observations he would locate the McBurney point about one inch nearer the anterior superior spinous process than the umbilicus.

With the exception of recurrent cases the treatment of non-perforating appendicitis only indirectly interests the surgeon, as the treatment is entirely medical, or at any rate should be. At the beginning of the attack the pain is so severe as to require the use of opium, in the author's opinion, though he is fully alive to the dangers of its use. For the employment of opium he lays down this rule: Use as little of it as possible and for the shortest possible time. Immediately after the relief of the severe pain the remedy he chooses in preference to all others is calomel. In fact it will often be found to give more complete relief to pain than the morphia, on account of relieving the bowels of distention from gas. He prefers calomel to the salines on account of the tendency of the latter to cause vomiting.

There is but one treatment of the recurrent cases both with and without perforation, operation. While an operation may not be so urgently demanded in recurrent cases of simple inflammation as in the perforating forms, still the disease in each case is always an inpending danger, and by it patients are rendered to a greater or less extent invalids. In regard to operating between attacks, he states that he has operated both in the intervals and at the time of acute exacerbation, and he knows of no good reason why one time rather than the other should be selected. The difficulties and dangers are much the same.

As to the second class, appendicitis with perforation, he looks upon rigidity of the abdominal muscles as an important physical sign as always indicating the presence of pus somewhere in the abdominal cavity. In any case of doubt as to the exudation, by the administration of a little chloroform the muscular spasm is relaxed and the necessary examination satisfactorily made. The author does not assent to the proposition of immediate operation in all cases of appendicitis, because he feels certain that more than one half of the cases of appendicitis are of the first class, and will fully and permanently recover with medical treatment alone. Again, by a delay of three or four days we become reasonably certain, in a majority of cases, whether we have to deal with a simple or perforating inflammation of the appendix. While it cannot be denied that this delay is attended with some danger still, on the whole, it will not be so great as that which follows the removal of the appendix in even simple cases. He sums up the treatment of this class as follows. Operate as early as possible, and remove the appendix when it can be found. All cases of this kind require drainage. Whenever a pocket of pus extends down into the pelvis, or under the liver or deep upon the median side of the cæcum, he has employed glass drainage-tubes in addition to the gauze. In the smaller or more accessible cavities the gauze alone is sufficient.

Of the third class, perforative appendicitis, not walled off, attended always by a diffuse septic a peritonitis, he say: Of all the abdominal emergencies that occur, this is as formidable and rapidly fatal as any, except hæmorrhage. It goes without saying that the only treatment is the earliest possible operation, but unfortunately, however early that may be done, with rare exceptions it will fail to avert or retard the unfortunate issue. Operation should always be done where the condition of the patient is not desperate enough to make it entirely hopeless. The author points out the fact that the symptoms of this form of appendicitis and acute obstruction of the bowels from bands of adhesions are so similar that occasionally mistakes will be made, though the prognosis is much more favorable after operation in the latter.

The remaining paper in this issue are:

"Dermoid Cyst; Broad Ligament Cyst; Vicious Union of the Cervix with Vagina," by George Erety Shoemaker, M. D., and the description of specimens of pus tubes, etc., by Dr. Joseph Price.

In the Department of Pædiatry, Dr. Edwin E. Graham describes "A case of Neurotic Œdema"

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## THERAPEUTICS.

### The use of Peroxide of Hydrogen as a Hæmostatic.

In the *New York Medical Journal*, Dr. Brewer recommends peroxide of hydrogen for the purpose of stopping hemorrhage. He has found it of great value in a number of cases. He states that it has been thought by some that the hæmostraic action of this drug is due in great measure to the fact that the peroxide-of-hydrogen fluid when brought into contact with organic matter is rapidly decomposed, giving off free nascent oxygen. This by uniting with the hæmoglobin, converts the blood, which is generally venous in character and charged with carbon dioxide, into bright arterial blood, which, it is well known, is much more readily coagulable than the vitiated fluid.

Rrewer was, however, led to question the correctness of this theory when he observed that in some of his most alarming cases the bleeding was distinctly arterial in character, and that these cases seemed to yield to the treatment as readily as those in which the oozing was undoubtedly venous.

Dr. W. G. Thompson placed the writer in possession of some facts which he observed during a series of experiments with this agent.

He observed that when a strong solution of peroxide of hydrogen (fifteen volumes or more) was brought into contact with the blood by being directly injected into the veins during life, it caused a rapid disintegration of the red corpuscles, resulting in the immediate precipitation of a semi-solid detritus which completely occluded the smaller vessels; that this effect extended so rapidly throughout the vascular system that within a comparatively short space of time the animal operated on would present the appearance characteristic of the most profound anæmia.

Thompson also observed that the application of strong solutions of this agent to mucous and serous membranes caused an almost immediate degeneration of the epithelial cells, resembling at first a rapid and exaggerated cloudly swelling, and later a complete destruction of the tissue.

In view of these facts, the writer is inclined to believe that the arrest of hemorrhage which is observed when strong peroxide of hydrogen is applied to a freshly-wounded surface results from this remarkable disintegrating action both on the tissues and the blood, rather than the simple oxygenation and rapid coagulation of the latter, for it is easy to understand how the rapid swelling of the endothelial lining of the cut blood-vessels and the soldification of the blood would result in a more or less complete obliteration of their lumen.—*Ther. Gazette.*

### The Nails.

Sulphur is especially useful in improving the nutrition of the nails. Sulphur is a normal ingredient of nail-tissue, in which it exists in a comparatively large proportion. It is consequently an excellent remedy in cases where the nutrition of the nails is perverted. In such conditions sulphur may be justly regarded as a specific nutrient remedy.

The mode of administration is an important point. It should be given regularly for a lengthened period in minute doses, such as five grains three times a day. Administered in this manner sulphur not only directly supplies the nail with an element necessary to its healthy life, but it also exerts a beneficial influence upon the composition of the blood. Sulphur is of material assistance in the treatment of the constitutional disorders upon which the trophic changes in the nails depend. This remedy possesses a decided value in the management of chronic rheumatism. From its action upon the liver and intestinal glands, sulphur is noticeable in the treatment of anemia and chlorosis. I have found sulphur of much value when the nails are brittle and marked by white spots or ridges. As an excellent local application in the same conditions, I can recommend an ointment containing from ten to sixty grains of the oleate of tin to the ounce of excipient. To this, for the sake of elegance may be added a little carmine. When rubbed along the nail and the surface surrounding it, the ointment of tin oleate improves the structure and luster of the nail.

### The Treatment of Scleroderma.

According to the Berlin correspondent of the *Medical Press and Circular* for February 14, 1894, at the last meeting of the Dermatological Society, Schutte showed a man whose illness began with pain in the knees and elbows, and with the formation of red, painful rhagades. The disease progressed slowly over the lower extremities and the right arm, and diminished greatly the usefulness of the limbs. Several methods of treatment had only a passing effect. On admission, the skin over the lower extremities and the buttocks was smooth, shining, hard and firm; bright and dark pigmented spots were irregularly scattered about. The patient could scaraely move the limbs; he mounted the steps as if the knees were anchylosed. The temperature of the skin was lowered. The treatment consisted of lengthened sitz baths, with succeeding massage with five-to-ten-per cent. salicylic vaseline. The salicylin was increased as improvement progressed. The patient gradually regained power of movement of the extremities. A small quantity of salicylic acid could be determined in the urine, so that some must have been absorbed through the skin. The favorable influence

of such treatment has been previously demonstrated in the case of a female shown to the society. In that case the improvement had been maintained.

## MEDICINE.

### The Treatment of Tonsillitis by means of Injections into the Substance of the Gland.

Prof. V. Ziemssen read a paper on this subject at the Congress of Medicine held at Weisbaden, April, 1893. Injections of a solution of carbolic acid were first recommended by Traube and Heubner in scarlantina. V. Ziemssen had found them useful in the various forms of tonsillitis, catarrhal, follicular, and phlegmonous. He was induced to try this treatment by this consideration that most cases of tonsillitis are caused by some infective virus. All recent investigations into the pathological anatomy of the tonsils have shown that in the follicles there are colonies of micro-organism of all kinds; indeed, they are found in the follicle healthy of tonsils, but it appears that, as long as the epithelium is healthy, they do no harm. When, however, the epithelium is in any way injured, they make their way into the substance of the tonsil and set up inflammation there. In the sore throat of scarlatina, in severe cases, there are nearly always small abscesses in the centres of the tonsils, from which foci inflammation spreads to the cervical lymph glands, and may cause general septicemia.

Von Ziemssen's treatment in cases of catarrhal tonsillitis consists in injection of seven minims of a two-per-cent. solution of carbolic acid into the middle of each tonsil. He uses for this purpose a specially constructed syringe. Soon after the injection pain and difficulty in swallowing diminish, and the temperature becomes normal. Usually only one injection into each tonsil is necessary. Sometimes a second is required in order to check inflammation. It might be said that the fall in temperature was due to the natural termination of the attack. From the constancy, however, with which this fall followed the injections, and the immediate improvement of the symptoms, Von Ziemssen believes the injections check the activity of the active microbes which are causing the inflammation. The injections are easy to carry out, and do not irritate the throat.

Sahli (Berne), in the discussion which followed, stated his agreement with V. Ziemssen as to the beneficial effect of this treatment both in tonsillitis and in scarlatinal sore throat. He said that latterly, instead of carbolic acid, he had been using iodine trichloride, a strong antiseptic, yet not a very poisonous body. He uses a two-per cent. solution of this body in water, and injects one or two minims of this into the tissues in different places once or twice daily. He uses this method in diphtheria with surprisingly good results. He strongly recommends this treatment for general adoption, and adds that he uses an ordinary hypodermic syringe, and that the procedure is extremely simple and easy to carry out.—*Centralblatt f. innere Med.* and *Dublin Journal Medical Sciences.*

### Olive Oil in the Treatment of Nephritic Colic.

Aussilloux (*Bull. Gener. de Therapeutique*) reports two cases of nephritic colic, occurring in elderly persons, in which the administration of olive oil produced most excellent results. The action of the oil in controlling the crises of the disorder was undoubted. How the drug acts, whether directly upon the calculi themselves or owing to its cholagogue or purgative properties was not determined. The action is apparently a reflex one, though even this cannot be accurately demonstrated clinically or experimentally. The oil stops the spasms of the ureters, as does a hypodermic injection of morphine, with the important difference that in the case of the latter remedy the relief produced is only temporary, whereas in the case of the oil it is definite. The oil seems to act in nephritic colic precisely as it does in hepatic colic, about which many observations have already been published. Regarding the administration of the oil, some practitioners prefer to give it in single doses of from 150 to 400 grammes or more. The author, however, recommends small quantities at a time, repeated as required. He refers to a singular method of administering the medicament in certain parts of France,—that is, in garlic broth; this is prepared by boiling a few cloves of garlic in water with a little salt. The broth is then poured over slices of bread soaked in the oil, constituting in this manner garlic soup. The author leaves out the bread and increases the amount of the oil from two to four tablespoonfuls. Patients take this beverage more readily than the pure oil, and it has been found to be just as efficacious. The dose may be repeated in the course of a few hours, if necessary.

## ARMY AND NAVY.

So much of Par. 13, S. O. No. 79, A. G. O. as relates to Major Peter J. A. Cleary, Surgeon, is so amended as to direct him on being relieved from duty at Fort McPherson, Georgia, to report for duty at Fort Wingate, New Mexico, instead of Fort Custer, Montana, for duty at that post, to relieve Major Washington Matthews, Surgeon.

Major Matthews on being so relieved will repair to Washington City and report in person to the Surgeon General for temporary duty in his office.

Par. 2, S. O. No. 68, A. G. O. is so amended as to direct 1st Lieut. Harlan E. McVay, Assistant Surgeon, on being relieved from duty at San Carlos, Arizona Territory, by First Lieutenant Straub, Assistant Surgeon, to report for duty at Angel Island, California, instead of Fort Huachuca, Arizona Territory.

Leave of absence for one month is hereby granted Captain Ogden Rafferty, Assistant Surgeon, with permission to apply for an extension until the 20th of May, next.

The following named officers of the Medical Department will report in person for temporary duty until further orders as follows:

First Lieutenant Charles Willcox, Assistant Surgeon to the Commanding Officer, Angel Island, California.

First Lieutenant Charles E. B. Flagg, Assistant Surgeon to the Commanding Officer, Alcatraz Island California.

## NEWS AND MISCELLANY.

### In the Name and by the Authority of the Commonwealth of Pennsylvania State Board of Health.

PROCLAMATION.

WHEREAS, Reliable information has been received by the State Board of Health that small-pox exists in the Borough of Danville, county of Montour, and that, notwithstanding the energetic and well-directed efforts of the Board of Health of the said borough, new cases of the disease are daily occurring.

AND WHEREAS, The State Board of Health also has knowledge that this disease has been carried from the Borough of Danville and county of Montour to other cities and counties in the State,

AND WHEREAS, Distance from the seat of the epidemic affords a community no security against the transmission of this disease, inasmuch as its germs may be transported the entire length of the State in twenty-four hours,

AND WHEREAS, It is the duty of the State Board of Health "to enforce such regulations as will tend to limit the progress of epidemic disease," and "to enforce such quarantine in places having no local health authorities,"

*Now, Therefore*, The State Board of Health hereby declares small-pox to be epidemic in the said Borough of Danville and county of Montour, and, with the object of preventing the further spread of the disease throughout the State, promulgates the following

ORDERS.

*First.*—All Borough Councils which have not already complied with the requirements of the act of May 11, 1893, by establishing Boards of Health, are hereby enjoined to perform this duty without further delay.

*Second.*—All Boards of Health are required to report immediately to the Secretary of the State Board of Health the existence of the first case of small-pox within their jurisdiction, and each week thereafter to report the additional cases as follows—Number of new cases during week: Number of cases released from quarantine: Number of deaths to date: Number of cases treated at their homes: Number of cases under treatment in hospital: Number of houses infected: Number of vaccinations: Precautionary measures: and also to publish an exact and true copy of such report in at least one local newspaper.

*Third.*—It is the duty of all Boards of Health to determine on a location for an emergency hospital in case this disease should become epidemic in their jurisdiction.

*Fourth.*—It is the duty of all Councils and Boards of Health to make provision for the free vaccination of such citizens as are unable to pay for the services of a physician.

*Fifth.*—All County Commissioners and Poor Directors are enjoined to hold themselves in readiness to provide emergency hospitals, nursing care, medical attendance and food for those who may be stricken with small-pox not residing in incorporated municipalities, and who are unable by reason of poverty to provide themselves with these necessaries, and also to furnish guards for quarantined houses and free vaccination, if the public safety requires the same.

*Sixth.*—All City and Borough Councils or Boards of Health and Boards of School Directors not having already in force ordinances or regulations of an effective character for the suppression of small-pox, are enjoined to immediately adopt the following equivalent odinance or regulations, and the same are hereby declared to be in force in all cities, boroughs, districts and places having no local Board of Health, in which the local sanitary laws and regulations are inoperative.

REGULATIONS.

1. It shall be the duty of every adult and every parent, guardian, or master of every minor, who has not had small-pox, or been vaccinated so as to have taken cow-pox regularly, if an adult, to be vaccinated, or in case of a minor, to cause such minors to be vaccinated.

2. No pupil shall be allowed to attend school, who has not been successively vaccinated within seven years.

3. Every school teacher or school officer who discovers a case of this disease among the attendants on the school must report the fact immediately to the local Board of Health, or, if there be no local board, to the State Board of Health. All school books which have been exposed to the infection of small-pox must be burned.

4. Whenever any householder knows that any person within his family or household has small-pox, he shall immediately report the same to the Board of Health, giving the street and number or location of the house.

5. Whenever any physician finds that any person whom he has called upon to visit has small-pox, he or she shall immediately report the same to the Board of Health, giving the street and number, or location of the house, on the receipt of which report the Board shall immediately notify the teacher or principal of every school, academy, seminary, or kindergarten in the district instructing said teacher or principal to dispense with the attendance of all pupils residing in the said family. No physician who may in good faith, in obedience to this ordinance, report a case as one of small-pox, which subsequently proves not to be such, shall be liable to a suit for damages for such error in reporting.

6. It shall be the duty of physicians and of all other attendants upon persons affected with small-pox to avoid exposure to the public of any garments or clothing about their own persons that may have been subjected to the risk of infection.

7. Every house in which small-pox exists shall be distinctly marked with a placard or flag.

8. There shall be no public or church funeral of any person who has died of small-pox, or of any person who has died of any other disease in a house in which small-pox was present at the time of such death.

9. The body of any person who has died of Small-pox shall not be exposed to view. Such body shall, immediately after death, be wrapped in a sheet which has been soaked in a solution of corrosive sublimate, in the proportion of two drachms to the gallon of water, or in an antiseptic cotton wool blanket, and privately buried within twenty-four hours.

10. No person shall unnecessarily visit any house in which small-pox is known to exist, or has existed within a period of six weeks.

11. No member of a family in whose house small-pox exists, and residing in such house, shall attend a public or private school, Sunday-school, church, theatre, circus, or any other public assembly, visit any market, shop, or store, or ride in any public conveyance.

12. No persons recently recovered from an attack of small-pox, or in whose family small-pox exists, shall go to work in any factory or mill without a certificate from their attending physician, stating that in his opinion such person run no risk of conveying the contagion, which certificate must be endorsed by the Board of Health, if there be one.

13. The period during which a person who has had small-pox, is in danger of conveying the contagion is at least six weeks from the commencement of the attack. The period within which a person who has been exposed to small-pox may develop the disease is eighteen days.

14. All rooms and houses in which small-pox has occurred, and all clothing, bed-clothing and articles of furniture which have been exposed to infection must be disinfected in accordance with the instructions of the Board of Health.

15. All cellars shall be thoroughly cleaned and white-washed, and all house-yards and privies treated with quick-lime, chloride of lime, or copperas, and kept clean.

NOTE.—For the purpose of this proclamation, all cases of varioloid shall be considered as small-pox. Any person who shall fail to obey or who shall violate the above regulations, become liable to a FINE OF $100 FOR EACH SUCH ACT OF NEGLECT OR VIOLATION.

The circular of the Board, No. 8, Precautions against small-pox; No. 31, Precautions to be adopted by Funeral Directors to prevent the spread of Contagious and Infectious Diseases; No. 41, Personal Precautions recommended to be taken by physicians in attending those suffering from certain communicable Diseases, and No. 37, on the construction of Emergency Hospitals, can be obtained of the local Board of Health, or by addressing the Secretary of the State Board of Health.

By order of the Board,

BENJAMIN LEE, M. D.,
*Secretary and Executive Officer.*

Executive office, 1532 Pine Street, Philadelphia, April 2, 1894.

**Commonwealth of Pennsylvania, State Board of Health.**

PHILA., April 11, 1894.

*To the Secretary of the State Board of Health:*

DEAR SIR:—In compliance with the resolution adopted by the International Conference of State Boards of Health at Toronto, October 6th, 1886, it becomes my duty to inform you that small-pox now exists at the following named places in this State, the number of cases at each place being named:—

Danville, Montour County, twenty-two cases, three deaths having taken place.

Washingtonville, Montour County, one case.

Lewisburgh, Union County, eleven cases, all in one house.

Riverside, Northumberland County, two cases.

Sunbury, Northumberland County, one case.

Pottsville, Schuylkill County, one case.

Shickshinny, Luzerne County, one fatal case.

Philadelphia, one case.

All of the above cases have been traced directly to Danville. The local physicians having failed, or refused, to recognize the true character of the disease, it had existed more than a month before the State Board of Health discovered it.

Harrisburg, Dauphin County, one fatal case.

Mohn's Store, Berks County, one case.

Sinking Springs, Berks county, one case.

Pittsburgh, Allegheny County, four cases.

The disease has disappeared from Reading, Tyrone Forges, Williamsport and Wilkinsburg. The outbreak at Tyrone Forges should have been credited to Danville and not to Reading.

I take the liberty of enclosing a copy of the proclamation issued by this Board, declaring the disease epidemic in the borough of Dansville and County of Montour.

All precautions are being taken as regards vaccination, isolation and disinfection.

Yours respectfully,

(Signed) BENJAMIN LEE,
*Secretary.*

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**Resident Physicians at the Methodist Episcopal Hospital of Philadelphia.**

An examination for two Resident Physicians at the Methodist Episcopal Hopital of Philadelphia will be held on Thursday, May 3rd, 1894, at 7.30 P. M., at the Hospital, Broad and Wolf Streets.

One of the officers thus selected will go on duty August 1, 1894, and serve twelve months. The other will go on duty September 1, 1894, and serve for thirteen months.

In accordance with the Charter of the Hospital, applicants must have the degree of Bachelor of Arts in addition to that of a Doctor of Medicine. Further information may be obtained from

JOHN B. ROBERTS, M. D.,
Chairman of the Committe on Examinations,
1627 Walnut Street., Philada.

THE
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# ORIGINAL ARTICLES.

## HYDROPHOBIA.

HIRAM CORSON, M.D., Plymouth Meeting, Pa.

Our first reliable account of rabies was by Aristotle, 322 years before Christ. He thought all animals except man were liable to the disease by inoculation of one from another. Virgil, Horace, Plutarch, and others, 130 years before Christ, gave interesting accounts of the disease; and in the second century after Christ, Galen spoke of it as the worst of diseases and recommended as a preventive excision of the wound. From the time of Galen to that of Rhazes, A. D. 922, but little was written concerning it. In the present century the writers have been numerous, as nearly all who publish works on the Practice of Medicine treat of it, but merely speak of it as it has been regarded by writers of an earlier period.

In the writings of two hundred years ago we find the disease was as accurately described as it is in those of our own times. All of them alike speak of the cause of rabies, the symptoms, the invariably fatal ending, and the means of prevention—by getting the virus from the wound or destroying it there.

Since I was appointed to report on this subject, I have carefully gone over seventy-eight long columns in the Encyclopedia of 1797; the one hundred and one pages of the Transactions of the American Medical Association, embracing 106 cases of rabies reported by the Committee of that Association in 1856; the interesting account of it contained in *Erichsen's Science and Art of Surgery;* and last, the more recent and exhaustive history of the disease given by Ziemssen in his *Cyclopedia of the Practice of Medicine*, where forty-two pages are given to the disease as it is manifested in dogs and other domestic animals, and forty pages as it is exhibited in human beings. As Ziemssen has embraced in his article all that was known up to his time, 1875, and in which he differs scarcely at all from all former writers, his declarations may be considered as reliable information as is attainable. To make copious extracts even from this voluminous report, which embraces all that is known on the subject, is unnecessary, and I shall briefly summarize it.

The cause of the disease in man is generally from the bite of a rabid dog, or the application of the saliva to an abraded surface or an incision through the skin. It *never* occurs spontaneously even in dogs.

The experiments of Herbing conclusively show that the saliva of a rabid dog is inactive when brought in contact with the healthy and unabraded mucous membrane of the mouth and alimentary canal. Pasteur and his disciples say exactly the same. In the time of Aristotle it was considered the most fearful of maladies and that by merely coming in contact with the body, or by treading upon the saliva of one affected by rabies, the disease might be contracted.

Even now there are districts in Europe, namely, the military frontier of Austria where the disease is frequent, in which the dread of it is so great, say historians, that human beings who suffer from it are shot

by their neighbors or not infrequently commit suicide. Even in my boyhood it was understood by us that if a person had hydrophobia he must either be bled to death, or smothered under feather beds. And only three or four years ago the newspapers reported a case of rabies, near to or in Atlanta, which could not be kept under the bed by four men, who were on it, but when they get two more on they succeeded in controlling him—whether by smothering or not, they did not state. How I suffered night and day when young Charles Rossith, one of my school-mates and a boy of my own age, was said to have hydrophobia and I supposed would be smothered under feather beds, I shall never forget. The young boys about the neighborhood gathered in groups agonized by what the poor lad was to undergo.

SYMPTOMS IN DOGS. — Ziemssen says that the symptoms described 200 years ago, were given as reddened eyes, drooping tail, projecting tongue and foaming mouth. These will do for the present time as well. But two or three pages are filled with an account of the many phenomena shown by different cases in the prodromic stage.

Two forms of rabies have long been recognized. The authors of long ago described them as the *Violent Form* and the *Sullen Form*. Pasteur's two forms he names: the *Furious* form and the *Paralytic* form.

The *Furious* in which there is delirium and disposition to bite. The *Paralytic* in which the animal is mute and paralyzed. In the *Furious* form the maniacal spells appear only spasmodically, while in the invals, the spasms are present only to a slight degree. The *Furious* attacks may last several hours. *No special dread of water exists.* In very rare instances do animals suffer from spasms of the throat in attempts to drink water. A discharge of foam from the mouth is scarcely ever seen. Saliva is emitted only when there is inability to swallow. When death is near, the pulse is small and thread-like, the breathing labored and the pupils dilated. At times partial convulsions set in. Death on 5th or 6th day; rarely later than 7th or 8th; never prolonged beyond the 10th; invariably fatal.

The *Sullen* or mute form constitutes only about 15 or 20 per cent; it runs a shorter course; the victims are less active; are silent and depressed; not disposed to leave home—which in the furious form the dog is disposed to do—or gnaw or bite. Paralysis of the lower jaw supervenes, with difficulty in swallowing, almost everything taken into the mouth falls out, and frothing appears. There is a changed voice, loss of appetite, constipation, rapid emaciation, paralysis of hind parts and fatal termination more quickly than in the furious form, namely, within two or three days.

In other domestic animals there are the same symptoms as in dogs. *In none of them is there dread of water.* They lap it eagerly so long as there is no difficulty in swallowing.

There are few authors who regard this affection as having been properly named hydrophobia, as persons suffering from it *have no dread of water.* Our eminent Pasteur says, emphatically, "*Dogs with rabies have no dread of water.*" This is true also in man, as has been shown in many cases.

THE DISEASE IN MAN.—In man the initiatory symptoms are said to be slight chills and heats, alternating; some pain or discomfort in the forehead; restlessness, and loss of appetite. "But one of the earliest and most persistent symptoms is an extreme degree of mental agitation and terror," says Ziemssen.

INCUBATION.—Ziemssen says "it varies extremely. In six per cent. of all cases, it varies between three and eighteen days. In sixty per cent., between eighteen and sixty-four days, while in thirty-four per cent. it exceeds sixty days." Haubner writes, "Eighty-three per cent. were within two months: sixteen per cent. within three months, and only one reached four months. The duration of the disease when fairly established is very short; rarely longer than from one to six days. In the 106 cases reported by the Committee of the American Medical Association, the great majority died within four days,—and this is the time given by most writers.

SYMPTOMS.—These are so various, if the actions of the patients are regarded, that nothing definite can be said. In some, the disease is manifested suddenly and is so evidently the result of fear and not actual disease, that the symptoms will be as varied as are the mental and nervous organizations of the patients. They are not as characteristic of the disease as are the symptoms which declare inflammations

of the brain, or the thoracic and abdominal organs. Respiration as a rule is, in quiet cases, normal during the intervals, but during the paroxysm, "it is gasping, irregular, quite rapid, and sometimes accompanied by decided dyspnœa," says Ziemssen. These convulsive respirations (by lookers-on called convulsions) are similar, I have recently been told, to those produced by the sudden entrance into a cold bath, or having cold water suddenly poured on the back of the neck, and are accompanied with spasms of the throat, and sometimes there is vomiting of a foaming, mucus, dark-colored substance resembling coffee grounds. It is useless, now, to give a long account of symptoms, as no writer claims that persons suffering with hydrophobia bark like dogs, or perform other acts which indicate that the dog's nature has been, by the virus, developed in or transmitted to man; and yet scarcely a single case occurs without it being asserted by those in attendance upon it, that the patient was fearfully affected with spasms on seeing water, and barked like a dog, and tried to bite those near to him. In Dr. Leedom's case, the young man who believed himself the victim of hydrophobia was actually going around on his hands and feet like a dog.

We are then rid of two of the symptoms: the barking and the dread of water; and if we could prevent the mental terror we would probably divest the disease of its most agonizing feature and be able to treat it as scientifically and successfully as we treat tetanus.

It is quite time that our profession with its present great enlightenment and immense resources should not stand idly, helplessly by the bed-side of the afflicted patient. We should investigate the case; discover if possible what vital organs are affected; where death has made his attack; and, then bring our weapons of defense and aggression to bear upon him and thus rescue our patient. I have no belief in the incurable character of this disease, if by any means we can rid the patient of his mental terror. I have a confident hope and an earnest belief that Pasteur or some other close observer and investigator of disease—possibly one of this audience—will find a remedy to successfully combat the disease even when at its very height.

CAN THE DISEASE BE PREVENTED? From the days of Aristotle to the present time, while the disease seemed to be rather a mysterious one, it was generally regarded as an affection of the brain and spinal marrow. One of the observers of 200 years ago queried whether it is not *wholly* a nervous disease.

Celsus, in order to prevent the virus from acting on the nerves of the part, as well as to prevent absorption of the virus into the system, recommended, as I have already said, the application of cups over the wound. And Galen, in the second century after Christ, recommended excision and cauterization of it; and from that day to this, one or the other, or both, have in all cases where danger was feared, been resorted to by physicians with almost if not quite unvarying success. The celebrated English veterinary surgeon Youat, with an experience beyond that of any one of his time, used caustic on the wound without a single failure. It is many years since I read his book, but I distinctly recollect that it was always successful if done before the accession of the disease. He used only the nitrate of silver. In our own country physicians have depended on excision or caustic, or both; and, so far as I have heard, without one failure in the thousands of persons thus treated. I have incised some and cauterized others and given to them such assurance of their safety that the mind of the patient was set at rest, and the result was good in every case. Strong, truthful, and encouraging as is the above testimony coming down to us through twenty centuries, what do we now hear the eminent Pasteur say? In a pamphlet published and circulated by one of his pupils who is trying to establish a "Pasteur Institute" for the prevention of rabies in those bitten by rabid dogs, at Red-Wing, Minnesota, it is boldly asserted that "the experience of Pasteur and his aids, with a practice vastly greater than any one else with rabies, is that *the use of strong caustics and the red-hot iron, is of no benefit, but rather an injury.*

How can we account for this rejection of preventive measures uniformly successful through thousands of years, by one who has been so great a benefactor to France? You will scarcely be willing to hear me say that it is simply because he has a preventive measure to introduce which will, if he can throw doubt on the value of the means referred to, bring him an immense revenue. I hope this is not

the cause and I earnestly hope a better, truer reason can be given for his change. But, when, in addition to this charge against the means of prevention long and successfully used, he bodly announces that the bite of even a healthy dog may cause rabies, and that it is only in a Pasteur Institute prevention can be assured, and that large fees come to him from those who at great expense flock to his institute, I feel that he places himself on a plane lower than that on which Stoy of Fry stand. Nothing could be more efficient to bring patients to him from every section of our vast country than this declaration that the bite of even a healthy dog may cause rabies, and that the means of prevention used by physicians are not useful but injurious. It is sincerely to be hoped that the Red-Wing Institute will never be established.

Having given the modes of prevention in use by the profession every where and with great success, yet as they have been denounced by M. Pasteur as more than useless, it is appropriate here to give an account of his means to protect persons who have been bitten by a rabid dog from an attack of rabies.

He says: "I found out that the virus rabiesque loses its intensity by transmission to other animals. With the rabbit it increases, with the monkey it decreases. I took the virus direct from the brain of a dog dead from hydrophobia. With this virus I inoculated a monkey. The monkey died. Then with this virus already weakened in intensity, I inoculated a second monkey. Then with the virus taken from the second monkey I inoculated a third monkey, and so on until I obtained a virus so weak as to be almost harmless. Then, with this almost harmless virus, I inoculated a rabbit, the virus being at once increased in intensity. Then with the virus from the first rabbit, I inoculated a second rabbit and there was another increase in the intensity of the virus. Then, with the virus of the second rabbit, I inoculated a third one, then a fourth, until the virus had regained its maximum intensity. Thus I had obtained virus of different degrees of power. I then took a dog and inoculated him, first with the weakest virus from the rabbit, then with the virus of the second rabbit, and finally with the virus of maximum intensity. After a few days more I inoculated the dog with virus taken directly from the brain of a dog that had just died of acute madness. The dog on which I had experimented proved completely insusceptible to hydrophobia. The experiment was frequently repeated, always with the same successful results. But my discovery does not end here. I took two dogs and inoculated them with the virus from a dog that had just died of acute hydrophobia. I subjected the second dog to my treatment giving him the three rabbit inoculations, beginning with the weakest and ending with the strongest. This second dog was completely cured, or rather became completely insusceptible to hydrophobia. "*Whoever gets bitten by a mad dog has only to submit to my three little inoculations and he need not have the slightest fear of hydrophobia.*" (1884).

I have already given you the treatment used so long by Dr. Stoy, and without a failure according to the reports—also Dr. Henry Fry's cure or rather preventive treatment in hundreds of cases without a single failure, he says. So too, a Dr. Jos. Emery, of Chester county, was for a long time celebrated as having a preventive that, when properly used, never failed in protecting the person bitten. Of this, more in another place. It may be proper to speak here also of a means considered by the people of Ohio, during a time reaching beyond this century, to be always successful in preventing the disease.

In an article entitled, "Uses of the Madstone," I find that a person bitten applied the tongue to it, and the poison was supposed to be drawn from his system. Hundreds were reported saved. What, now, shall we believe in relation to these secret remedies and the madstone? The Stoy, Fry, and Emery preventives were all vegetable substances, and therefore might have had useful medicinal properties—even if they had not, then they prove that mad dogs—dogs with rabies—are exceedingly rare, and still more rarely are persons bitten by them, and that the numerous fatal cases now reported are cases of false hydrophobia, the result of mental anxiety and fear after being bitten.

No one of you hesitates for a moment in believing that the madstone has no saving power, and, yet, hundreds of people have resorted to it and are convinced of its value in the cases used. But no cases have been presented to show that the

exemptions from the disease were due to the means of prevention used.

I will name another remedy with some proofs that it has real value as a means of prevention according to the testimony of truthful, sensible men. It is the root of the Elecampane—this was Jos. Emery's cure—Stoy's was Chickweed—Fry's a mixture of plants. Some who affect to know say it was Elecampane.

Could every case of true and of false hydrophobia be divested of the mental terror consequent on what the patient had heard of the fearful agony attendant on the disease, as reported in the newspapers and narrated by those who have witnessed cases, or had heard of them in their youthful days, I doubt not that the disease would exhibit symptoms as distinctive and as characteristic as those of chorea or tetanus.

A few years ago Gen'l W. H. H. Davis, editor of the *Doylestown Democrat*, after reading my essay on hydrophobia, published copious extracts from it followed by these remarks: "When a child I witnessed the chasing and shooting of a mad-dog, and, afterwards, listened to tales of horror, told of persons who had been bitten and who had been smothered under feather beds and otherwise hastened to the end of life, that their sufferings should cease. That day of horror has never entirely passed from my memory. I hail with satisfaction anything that may save other children and even adults from unnecessary suffering. If in this age, when the achievements of mind over matter are more clearly understood and recognized, it should transpire that disorders of the nervous system can be treated and cured by the allaying of nervous fears, humanity will lose some of its most excruciating suffering."

Such were his utterances. That the members of this Society should take this subject under consideration must be apparent to us all. As physicians we know that there is nothing in the actual diseased condition of any of the body organs—the mental conditions not being taken into account—which could produce the fearful agony, the horrible manifestation of suffering described as always being attendant on the malady. There is not a single case given to us by the newspapers, from the pen of an eye witness, but is reported as being accompanied by horrible agony and superhuman strength and an uncontrollable disposition to injure others, and yet post-mortem examinations have proved that there is no evidence of there having been disease which could have produced such suffering.

The fact that the patient afflicted with madness brings before himself the horrors which from childhood he has heard described as the invariable attendants upon it, impels him to perform the acts and exhibit the fury of which he has so often heard. Speculative theories must yield to facts. Every writer on this disease speaks of the rapid weakening of the body, day by day, until death ensues. And, yet, this poor sick person in nearly every case is restrained by cords, bound hand and foot, or held down by strong men, or partially, if not entirely, smothered under feather beds—as in the case reported two or three years ago, as occurring in or near Atlanta, where four men on the top of the bed couldn't keep the victim down, but when two more got on he was quieted—whether dead or alive was not stated.

Our profession confesses its inability to successfully cope with this disease. This should not be. We have left to the proprietors of secret remedies, and the owner of the madstone almost the entire care of those bitten by mad dogs.

It is a reflection on our noble profession that we have wholly neglected to investigate this malady and bring our remedies to bear upon it.

(TO BE CONTINUED.)

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A GREAT INVENTOR.—Mrs. Hogna.—"And fwy isn't the old mon a-workin' now?"

Mrs. Grogan.—"It's a invintor he is. He has got up a road-schraper thot does the work of foive min."

Mrs. Hogan.—"An' how minny min do it take to r-run it?"

Mrs. Grogan.—"Six. It will be a great thing for givin' imployment to the laborin'-man"—*Indianoplis Journal.*

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Boy—Me mother wants to borrow a cup of salt, please?

Mrs. Neighborly—She hasn't returned the cup of sugar she borrowed yet.

Boy—So me mother said, but, yer see, she wants the salt ter mix wid the sugar she returns.—*New York Recorder.*

# COMMUNICATIONS.

## THE SURGICAL RELATIONS OF THE THORACIC DUCT IN THE NECK, WITH THE EXHIBITION OF TWO DISSECTIONS MADE BY MR. WARD BRINTON.*

JOHN H. BRINTON, M. D., PHILADELPHIA.

I have here dissections illustrating the two most common terminations of the thoracic duct. I had always supposed that the anatomical relations of the ending of this duct were not more abnormal than those of any other duct or vessel in the body. But from the study of several dissections, and especially from the comparison of the descriptions given by various anatomical writers, I find great diversity in this respect. The general law is that the duct shall discharge its contents into the great veins, jugular and subclavian, at the base of the left side of the neck. This is done in several ways.

In the first of these dissections made by Mr. Brinton we have the regular, or normal type, the duct curving over the apex of the pleura and terminating exactly in the angle formed by the junction of the subclavian and internal jugular veins. In the second dissection we find the duct dividing into two branches, these forming a circle by their union above. From this circle one trunk arches outward and divides into three branches. Two of these empty into the subclavian at the distance of one-quarter and one-half an inch from the internal jugular junction. The third branch empties into the internal jugular. Between these divisions passes a communicating branch. A large branch is also given off from the right side of the circle. This passes upward, turns to the left, and, deeply seated, crosses the neck transversely. The last portion of this branch was uninjected.

From the examination of these dissections the two typical terminations of the thoracic duct as described by Meckel can be studied. In most cases it empties into the angle of union of the internal jugular and subclavian veins by one trunk; when more than one trunk exists the terminations of the thoracic duct are in both the internal jugular and subclavian veins. The duct as stated by this observer rarely opens into only one of these two veins.

In Quain's *Anatomy*, I find that the thoracic duct often divides into two or three branches, which terminate separately in the great veins, as in the second dissection on the table. Sometimes these several ducts again unite in a common trunk, and occasionally one of the branches may pass across and empty into the veins of the right side of the neck. The duct has also been known to terminate in the vena azygos. According to Sappey, there are many varieties of termination; Professor Harrison Allen, in his *Treatise on Anatomy*, states that the thoracic duct may empty into the jugular, azygos, and left innominate vein; infrequently it may be double. Sometimes as many as six terminal vessels are present, which are received into the subclavian, jugular, vertebral, and axillary veins.

The irregular terminations of the thoracic duct are alluded to by Henle and by Breschet. The latter, in his *Système Lymphatique*, describes minutely the many varieties, and instances one case, cited by Haller, from Bartholin, of the communication of a duct branch with the vena cava.

The formation of circles, or insulæ, as seen in the specimen before you, is also referred to. I might mention that the multiple termination of the duct is frequently met with in animals.

Hyrtt, so accurate and practical, tells us that the varieties of termination of the duct are very numerous, and do not in the least interest the practical surgeon. I cannot but think that the latter remark is too sweeping, especially in those cases where any portion of an arch formed by irregular terminal branches reaches high into the neck. If drawn upon or stretched by contracting and indurated tissues, and during operation, it might be easily cut

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or torn. In an instance where a duct branch passes transversely for a considerable distance to empty into the subclavian vein, it certainly might be readily endangered. It seems to be, therefore, that the possibility of irregular and manifold endings of the thoracic ducts must be considered by the practical surgeon, and that in operating in this deep seated, dangerous region he should bear in mind its normal abnormalities.

That I have not overrated the chances of accident to the thoracic duct, its terminations, will, I am sure, be evident to the Academy on the presentation of the next paper by Professor Keen.

## PINKROOT POISONING.

JAMES E. FREE, M. D., BILLINGS, MONTANA.

March 18, 1894, 10 A. M., Rolland M., two years and four months old, was given seven spoonfuls of an infusion of pinkroot and senna, for worms. At 2 P. M. he began to cry violently without cause, and kept it up until 3 P. M., when he looked, and acted queer; 4 P. M. threw his head back on the pillow, like a victim of meningitis, indulged in the hydrocephalic cry, began to jerk all over, and soon became unconscious.

7 P. M. temperature 107°, head hot, skin dry, respiration 50, bubbling râles over chest, breathing of the Cheyne-Stokes type. The inhibiting control of the respiratory centre over breathing was lost. The diaphragm seemed to act spasmodically. Breathing was at times stertorous, sighing, moaning.

Heart's action was irregular and tumultuous. The tongue was about natural in color and moisture. A bright red spot looking like hectic flush was on either cheek.

Pupils were widely dilated. Cornea presented the glazed appearance of a person in rigor mortis.

Pulse was too rapid to count. The most pronounced symptom was clonic contractions of the muscles. The chin, mouth, ears, scalp, eyebrows, were moved spasmodically as if the patient was subjected to an acute choreic attack. Abdominal muscles jerked almost constantly. Head was thrown back, and legs stiffened synchronously twice in a minute. Arms were constantly in motion. The bed, a large one, was rattled by the movements of child. Patient had been constipated for two days, and a nurse who was taking care of the child's mother in confinement diagnosed "worms," and administered the medicine to physic them out. The intestinal canal was in continuous motion, judging from the gurgling within the abdomen.

An injection of hot water brought away four copious evacuations, foul smelling, and containing much undigested food, and many berry seeds. The child had been fed a hard-boiled egg for breakfast.

After the stools, the sphincter was relaxed and patulous. Nothing was retained unless child was turned on his stomach, with trunk higher than head. This position interfered with respiration. No urine was passed during the day.

The mother of the child is an hysterical woman, below the average in intelligence, and has thyroid enlargement. The boy was not bright; bigheaded; and had the look of an epileptic. Symptoms increased in violence, and child died at 12 M.

The United States Dispensatory mentions poisoning by pinkroot as a remote possibility, and also says that it is combined with laxatives which prevent its narcotic action from being dangerous. In this case there was no amelioration of symptoms after profuse diarrhœa.

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WIDOW—I want a stone for my husband's grave exactly like the other one in the lot.

Agent—But isn't it a trifle small for a man of your husband's prominence?

Widow—No, sir! If Thomas thought a stone like that was good enough for his first wife, I guess it's plenty good enough for Thomas.—*Life.*

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AUTHORITY that needs to be frequently asserted does not generally last long.—*Milwaukee Journal.*

## FREEDOM FROM RECURRING APPENDICITIS AFTER EVACUATION OF THE ABSCESS AND RETENTION OF THE APPENDIX.*

JAMES M. BARTON,† A. M., M. D.

At the last meeting of the American Surgical Association I reported nine recoveries from operations for appendicitis in which the appendix was not removed. These were all cases of ruptured appendix with circumscribed abscess, with no general peritonitis and no symptoms of obstruction.

The operation consisted in opening the abdomen and using sterilized cheese-cloth to hold the movable intestines back and to protect the general peritoneal cavity while the abscess was opened and emptied. Drains were then introduced, some of the cheese-cloth permitted to remain, and most of the wound closed. No attempt was made to find or remove the appendix.

Before considering the later condition of the appendix in these cases I wish to report, briefly, five more cases upon whom I have operated in the same manner, all of whom also recovered.

Mr. B., aged twenty-three years, a patient of Dr. Cline, of Jersey Shore, Pa. He was operated upon August 24, 1893, on the seventeenth day of the disease.

William C. M., aged twenty years. The operation was performed at Jefferson College on August 28, 1893, on the third day of the disease.

Harry S., also aged twenty years. I performed the operation at the Philadelphia Hospital, September 4, 1893, on the seventh day of the disease.

Richard B., aged forty-four years. The operation was performed at the Jefferson College Hospital, September 17, 1893. It was the third attack, and the present one had existed for thirteen days.

Miss V., aged twenty-two years. The operation was performed November 10, 1893, on the third day of the disease. She was a private patient of Dr. M. B. Dwight, of West Philadelphia.

My object in bringing this subject to your notice is to exhibit several of these patients and to read reports from most of the others to show that none, whose histories I have been able to follow, have been at all troubled by the retained appendix, and to learn if the experience of the Fellows of the Academy have been similar to my own.

It is becoming widely recognized that this method of operation is accompanied by a low rate of mortality. Richardson in this country, Tait in England and Reclus and Schmidt on the Continent, as well as many others, content themselves in these cases of local purulent peritonitis with protecting the peritoneal cavity and draining. Others, however, still consider that no operation is complete without removing the appendix. In the March number of the *Annals of Surgery*, Fowler advises, in these cases, the removal of as much of the appendix as can be done without separating adhesions, but considers it necessary to remove the rest of the appendix at a second operation.

Of these fourteen cases, eleven were operated upon by myself during the last two years. All on whom I have operated in this manner have recovered, and none, that I am aware of, have had any trouble with the retained appendix since.

As the mortality has been much greater when I have removed the appendix, I now rarely do so unless the appendix is unruptured, or, if ruptured, only when general peritonitis has occurred.

Of these eleven cases I have been able to follow the history of eight, several of whom are here to-night for examination.

The three whom I have not been able to find were hospital cases; two of them were brought to the hospital by physicians. If either of these had had a recurrence needing surgical aid I should probably have known it.

Of the eight whose histories I have been able to follow, none have had the slightest symptom referable to the appendix since the operation. No tumor is to be felt, and no tenderness. Indeed, they all appear to have been singularly free from diseases of all sorts since the operation.

Mrs. C., aged thirty years, is here this evening, and will permit us to examine the region operated upon. The operation was performed November 29, 1892, and though she has been using the sewing-machine steadily ever since, she has enjoyed the

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†Surgeon to the Jefferson College Hospital and to the Philadelphia Hospital.

most robust health. The right iliac fossa is apparently entirely free from disease.

I also present Wm. C. M., aged twenty years. I operated upon him at Jefferson College Hospital, August 28, 1893. He has been in perfect health in all respects since the operation, and there is no evidence of disease in the right iliac fossa.

Harry S. has also been kind enough to come here. I operated upon him September 4, 1893, at the Philadelphia Hospital. He also has been in perfect health since the operation, and presents no evidence of disease anywhere.

Dr. Marshall, of Milford, Delaware, informed me a few days ago that the patient, Mrs. S., on whom I operated for him on February 26, 1892, has enjoyed perfect health ever since, and that on examination he has been unable to find any tenderness on pressure or any tumor in the right iliac fossa.

Dr. Beary, of the Falls of Schuylkill, reports that Mrs. R. T., on whom I operated for him January 20, 1893, has been in perfect health since the operation.

Dr. Cline, of Jersey Shore, Pa., reports that Mr. B. has been in perfect health since the operation; indeed, in better health than for a number of years before.

Dr. Dwight, of West Philadelphia, reports his patient, Miss V., as in perfect health since the operation, and on a recent examination of the seat of the disease there is no tenderness and no tumor to be felt.

Dr. Chandler, of Centreville, Del., reports: "The patient, Mrs. M., on whom you operated for me, April 3, 1893, has made a perfect recovery, and has been perfectly well ever since." He adds, "that from the operations in which he has participated he thinks the removal of the appendix in these cases is not required if good drainage is established. The appendix will take care of itself."

From the uniformity with which full and complete recovery has occurred in the few cases that have come under my care, it looks as though the appendix is not very liable to give trouble if permitted to remain. Indeed, I think it is quite likely, in cases such as we have been considering, that the opening from the appendix into the intestine is closed early in the attack—closed quite as firmly as any ligature would close it, and there is but little probability that fecal matters will ever be again able to enter the appendix either to cause a fecal fistula to follow the operation or to start another case of appendicitis in the future.

If it were not firmly closed, the pus would never have broken through the walls of the appendix, or, having broken through, the resulting abscess would not have increased in size, but would have emptied itself through the appendix into the bowel.

To further illustrate the strength of this obstruction at the base of the appendix I have observed, in several cases where fecal fistula followed appendicitis, that in none did the feces make their exit through the appendix, but through other portions of the intestines, showing that the inflammatory deposit closing the appendix was even stronger than the healthy bowel.

The mortality following operations for appendicitis is mainly due to general septic peritonitis and to intestinal obstruction.

If we will look into the cavity of a fully-developed abscess, such as we have been considering, we can readily see how these complications may follow the search for or removal of the appendix. The cavity of the abscess is lined with a thick layer of grayish, poorly organized, aplastic lymph, filled with micro-organisms. The appendix lies buried beneath this lymph, and its cavity communicates freely with the general abscess cavity. The opening can occasionally be seen, and is often the only guide by which the position of the appendix can be recognized.

To tear up this fragile and infected lymph, and distribute it through the peritoneal cavity while searching for and liberating the appendix, would greatly increase the probability of establishing a general septic peritonitis.

Intestinal obstruction following operations for appendicitis is probably due to kinking of the recently separated intestines. As they reunite, covered and stiffened as they are by inflammatory deposits, they cannot adjust themselves as readily as at the first formation of the abscess.

To avoid any misunderstanding, let me state that it is only in cases of circumscribed abscess that I have been permitting the appendix to remain.

When the appendix is still unruptured, or when it has ruptured and general peritonitis has occurred, or when obstruction is present, I am in the habit of removing it.

# VAGINAL HYSTERECTOMY.*

JOHN B. DEAVER, M. D., PHILADELPHIA.

MR. PRESIDENT AND FELLOWS:—I will not offer an apology for bringing before this body a paper upon "Vaginal Hysterectomy," as I am convinced that this line of work should not be delegated solely to those who work in the field of gynecology, but that it belongs as well to the general surgeon. In support of what I have said may I be privileged to ask the question: Is not the surgeon who meets with all forms of surgical complications better prepared to meet such than the limited specialist who has not had a general surgical training? Furthermore, if the general surgeon in the pursuance of his work has kept up his anatomical work, and opportunity has been given him to observe in hospital, as well as in private practice, the class of cases I propose to discuss this evening, I think you will agree with me that a paper on this subject by a general surgeon should not be considered out of place.

In the discussion of this subject I will consider it under the following headings:

Symptoms, diagnosis, prognosis, complications, anatomical relations, preliminary treatment, methods of operation, operation, report of cases.

SYMPTOMS.—The symptoms of carcinoma of the cervix may be so slight at first that the patient will pay no attention to them, but will attribute the sensations experienced to the change of life or menopause, at which time cancer in this locality usually makes its appearance. From the insidious character of the invasion, considerable involvement will generally have taken place ere the case comes to the notice of the attending physician or surgeon. A slight hemorrhage is noticed, following exertion or coitus, and occurring between the regular menstrual periods. This usually does not alarm the patient until it becomes a frequent occurrence. It has been compared to the hæmoptysis of early pulmonary consumption, but is unlike it from the fact that there is no active destructive change going on as yet. A leucorrhœal discharge is present, although without the characteristic cancerous odor. In the first stage the general or constitutional manifestations of cancer do not present themselves. Pain, however, is one of the earlier symptoms. There may be disturbance either of the digestive or nervous system, or of both.

Following this preliminary stage there is usually a period of latency when the disease seems to "rest upon its oars," prior to the second stage, when all the symptoms are present to a marked degree. The hemorrhages are more frequent, and at times are profuse. There is also present a sero-purulent, irritating discharge, with a penetrating, foul odor, and by contact with the internal and external genitalia giving rise to irritation and pruritus, which often cause as much distress as the primary disease. Pain is severe and radiating in character, and is felt most in the lumbar region. The uterus may be fixed or movable; as the disease progresses the uterus becomes fixed by extension of the disease to the surrounding pelvic structures. Examination with the speculum is often unsatisfactory, unless ulceration or granulation tissue be present; the finger more readily detects the character of the tissue, recognizing neoplasm from its consistency.

The general condition of the patient during the second stage undergoes a marked change. The digestion is very much impaired; anorexia, constipation, etc., are present, and give rise to systematic malnutrition. As a result of this general disturbance, what is known as the "cachectic stage" makes its appearance. The skin is dry and rough, and its color is changed to a muddy yellowish-brown tint.

DIAGNOSIS.—The conditions from which cancerous disease of the cervix might be defferentiated are the following: Lacerated cervix, with cervical catarrh; erosion of the cervix; specific ulceration; mucous patches; papillary growths; vaginitis; myoma, and sarcoma.

The diagnosis of the cervical carcinoma is in the main easy, as the cases are usually seen after positive ulcerative and other gross changes have taken place. Where there is simply thickening of the mucous lining of the cervix, with infiltration of the walls, and particularly where the cervix has been torn, it becomes somewhat difficult to differentiate from a long-standing case of cervical catarrh. When, in

*Read before Philadelphia Academy of Surgery, March 5, 1894.

addition to the above conditions, the cervix presents a nodular appearance from occlusion of the cervical glands, the difficulty is increased. This latter condition, however, should not be mistaken for carcinoma, as the nodules are characteristic of malignant infiltration.

If ulceration is present, and the ulcers present a punched-out, ragged appearance, bleeding freely from the slightest touch, suspicion should be aroused. On the other hand, ulceration consequent upon erosion of the cervical mucous membrane is regular in outline and the surface of the ulcer smooth.

Specific ulceration of the cervix, chancral and chancroidal, is rarely seen, and bears little or no resemblance to carcinoma, and in connection with the history of the case, age of the patient, etc., should not cloud the diagnosis.

Mucous patches and papillary growths are more likely to be confounded with the disease than the two preceding conditions; these are, however, distinguishable in that they are more numerous and more widely distributed.

The discharge which accompanies vaginitis in no way resembles that resulting from carcinoma.

Myoma of the cervix might be confounded with a single carcinomatous nodule, but differs from the latter in the absence of infiltration, inflammation, and adhesion of the overlying mucous membrane.

In incipient carcinoma of the mucous lining of the uterus before the body has become involved the only symptoms are the presence of a sero-sanious discharge, not necessarily accompanied by odor, and the general appearance of anæmia with debility and digestive disturbances. Pain may or may not be a feature of the case. These indefinite symptoms, together with the failure to respond to well-directed treatment, and the absence of disease of the uterine adnexa should warrant dilatation and curettement for purpose of diagnosis.

In carcinoma of the body of the uterus the presence of a serosanious discharge with the characteristic odor, associated with frequent hemorrhage and enlargement of the fundus, would warrant curetting and microscopical examination of the particles of tissue removed. This may be done without anæsthesia.

Sarcoma of the uterus is capable of giving rise to symptoms similar in many respects to those of carcinoma. While it is not always possible to differentiate between these affections, they each have symptoms peculiar to themselves.

The symptoms in favor of sarcoma are the presence of a rapidly-growing tumor of the uterus appearing rather earlier in life than carcinoma; hemorrhage, which is more or less constant, and severe pain.

The diagnosis of sarcoma can often be established by a digital examination, when the cervix will be found less patulous than in carcinoma, the tumor presenting the form of a polypoid growth, It may be necessary to dilate the cervix to explore the interior of the uterus, when, if a mass be found, a portion of it may be removed and examined.

PROGNOSIS.—As to the probable outcome of the operation of a vaginal hysterectomy for carcinoma, it is too early in the history of the operation to draw definite conclusions, but the results thus far have proved that especially early and even later operation prolongs life. There is no doubt but that removal of the uterus for carcinoma offers a longer immunity from return than does operation for the same disease in other parts of the body, if done early.

COMPLICATIONS. — Fatal attacks of uræmia may follow, though it is rare to have eclamptic convulsions.

By extension of the disease the bladder and rectum become involved, and as a result cystitis or vesico-vaginal or recto vaginal fistula may arise to add to the already deplorable condition of the patient. Peritonitis from extrusion would cause a speedy termination of the case, as would an embolus.

Pregnancy is a dangerous complication, as septicæmia or fatal hemorrhage is likely to ensue if the case be permitted to go to full term.

ANATOMICAL RELATIONS.—The relations of the ureters are of so much importance in this operation that I have thought it worth while to describe their course. They extend from the termination of the pelvis of the kidney to the bladder, passing through the laminæ of the subperitoneal connective tissue. Their average length is about twelve inches. At their commencement they lie about three inches apart, but on nearing the base of the bladder they

run foward and inward and pierce its wall, and at their termination are separated by a distance of about an inch and a quarter.

We may describe them as consisting of three portions—viz., abdominal, pelvic, and vesical. The abdominal portion is in relation posteriorly with the psoas muscle and its fascia, the genito-crural nerve, and the common iliac artery. Anteriorly they are covered by the peritoneum, and on the right side lie partly under the caput coli and ascending colon, and under the descending colon and sigmoid flexure on the left. About the middle of their course they are jointed by the ovarian vessels, which cross them to descend into the pelvis along their outer border. At the brim of the pelvis the right ureter lies just behind the peritoneum, where it can be seen with the ovarian vessels. On the left side the relations of the ureter to the sigmoid flexure depend entirely upon the length of the meso-sigmoid. Thus in one case the ureter may lie behind the sigmoid vessels, and in another directly behind the intestines. After crossing the psoas muscle it crosses obliquely over the common iliac artery above its bifurcation, dropping into the pelvis at this point.

The pelvic portion runs in front of the sacro-iliac synchondrosis, then upon the obturator internus muscle and its fascia, finally leaving the pelvic wall to join the bladder. It lies at first usually to the inner side of the internal iliac artery, subsequently to the outside, and is again crossed by the ovarian viens and artery, which leave it at an acute angle. It then descends in the lower cellular tissue to the floor of the pelvis in a forward direction, passing directly under the uterine artery, and through the uterine plexus of veins and beneath the base of the broad ligament. Finally it crosses the upper third of the vagina to reach the vesico-vaginal interspace, and pierces the bladder opposite the middle of the vagina.

The vesical portion, about half an inch in length, runs obliquely downward and inward through the coats of the bladder to open on the mucous surface at a distance of about an inch to an inch and a quarter from its fellow, and the same distance from the internal urinary meatus.

The uterine artery leaves the lateral pelvic wall at a point just above the ischial spine, reaches the vaginal wall at the level of the os externum, and then runs upward along the side of the uterus to reach the fundus.

Preliminary Treatment.—Much depends upon the preparation of the patient for operation. The most careful antisepsis of the vulva and vagina should be carried out. It is the practice of some surgeons to have the hair covering the soft parts removed ; I do not believe this necessary if this region be thoroughly scrubbed twice a day with some good detersive soap for two or three days prior to the operation. The vagina should be cleansed with soft soap, and then both the external genitals and vagina irrigated with a 1:60 carbolic acid solution containing an amount of bichloride of mercury to make it equivalent to 1:4000. The bowels should likewise be carefully regulated, and a mild laxative administered for a few days before operation to thoroughly clean out the lower end of the alimentary canal. If there be present granulations covering the cervix or occupying the uterine canal, or should the cervix be eroded and accompanied by a fetid discharge, it would be wise at first to curette away the granulation tissue exciting the discharge, and the vagina subjected to bichloride irrigations twice or thrice daily, the frequency depending on the character of the discharge.

Methods of Operation.—In the operation of vaginal hysterectomy one of three methods are practiced—the clamp, the ligature, and that by enucleation (Langenback's). There is no doubt but that the method by enucleation is the ideal one, and should be adopted when the case is suitable for it.

The enucleated method consists first in liberating the cervix by carrying two elliptical incisions through the vaginal wall in front of and behind the cervix, or by a circular incision carried around the cervix, the dissection being made close to the cervix. This should be the rule whatever method be employed. In the removal of neck tumors in the immediate neighborhood of large vessels, or, in fact, any tumor occupying an important vascular locality, the surgeon follows the practice of dissecting close to the tumor. The second step in the enucleation method is in making a sub-peritoneal dissection of the uterus. I think this should be the operation of choice in the early cases at least.

Between the clamp and the ligature method there is in my mind no doubt of

the superiority of the latter. I grant there are a few cases where the clamp method is probably the better operation, but these constitute the exception. The ligature method of vaginal hysterectomy is as much superior to the clamp as is the dropping of the stump in the supra-vaginal, having tied off the uterine appendages and ligated the uterine arteries, over that of the *serre-nœud*. The ligature is surgical, while the clamp compared to it is unsurgical.

In the selection of any operation, that which will leave the patient most comfortable, not, of course, exposing her to a single additional risk, should in my judgment be the one of choice. I am frequently confronted with the argument, "Why, the clamp method can be done in fifteen minutues and less." In answer to which my reply is, The ligature method can be done in thirty to forty minutes. The question of a few moments longer in doing the opertaion is of no import, as, if the case is suitable for a hysterectomy, there will be no shock. The loss of blood in the ligature method is no greater than that in the clamp, if done properly, and the security against secondary bleeding is much greater. The ligature method is one that can be made a strictly aseptic one, and maintained so throughout, while in the case of the clamp there is always some suppuration following, thus exposing the peritoneum to infection from without.

The question may arise, Why not close the wound in the vault of the vagina? The wound closes itself. I have observed, and demonstrated after the removal of the uterus, the almost perfect apposition of the cut surfaces; therefore, have never been able to see the necessity of introducing sutures. If bleeding follows reaction from the anæsthetic, and the wound in the vagina has been closed by sutures, it may be the cause of a subsequent abscess, while in allowing the edges of the wound to oppose naturally, and introducing a little packing of iodoform gauze into the vagina, not carrying it into the pelvic cavity, the blood finds its way into the vagina and is taken up by the gauze. By the time reactionary or consecutive bleeding, if you see fit to call it such, would occur, the wound in the vagina would not yet have been sealed off; therefore it finds its way out of the pelvis.

In either the ligature or the clamp method, when the cervix is entirely destroyed, thus making it impossible to grasp it with a vulsella or pressure forceps to pull the uterus down, my practice is to introduce a tenaculum into the uterus, by which I am able to make slight traction, and thus steady the organ; this allows me to free the vaginal walls and expose the supra-vaginal portion of the cervix, which I grasp with the vulsella, and thus command the uterus through the remaining steps of the operation.

*Operation.*—The bowels and bladder having been emptied, the patient is anæsthetized and placed in the lithotomy position, with her limbs held by assistants. A Sims' speculum is introduced and the cervix uteri exposed. The cervix is then grasped either by a vulsella or a pair of pressure forceps, the latter being less likely to slip or tear out. Traction is made upon the uterus, drawing it downward and forward to expose its under surface. An incision is carried across the exposed surface to the situation of the internal os, or as far away from the eroded tissue as possible, and with the fingers the posterior wall of the vagina and the areolar tissue are freed from the uterus down to the peritoneum. The forceps holding the uterus are then carried downward, and the incision continued to make it encircle the organ. The structures in advance of the uterus are dissected away in the manner before described, great care being observed to keep close to the body to prevent injury to the bladder; having reached the vesico-uterine folds of the peritoneum, the vagina is thoroughly irrigated. The recto-uterine and vesico-uterine folds of the peritoneum are now broken through, and, if the operator so desire, a small piece of gauze or sponge introduced to prevent prolapse of the intestine; this I do not believe, however, to be essential. The female blade of the clamp is then introduced along the palmar surface of the finger, which acts as a director. The blade of the clamp is made to hug the under surface of the broad ligament, and the end of the blade is made to pass beyond its upper limit. The handle is depressed to make the end appear above the upper surface of the ligament, the other blade introduced, and the clamp locked. The opposite side having been treated in the same manner, the attachments are severed and the uterus removed. Should difficulty be experienced in applying the second clamp, the attach-

ment of the side already clamped may be severed, and the body of the uterus loosened and delivered, when the clamp can be easily applied.

A piece of sponge or gauze is introduced, and the vagina is irrigated; gauze is loosely packed around the clamps to prevent ulceration of the soft parts from pressure, and a light packing placed in the vagina to act as a capillary drain.

The clamps may be removed at the end of the second or third day. In removal of the uterus by the ligature method the early steps are the same as in the clamp operation. Having freed the uterus from all its surrounding tissues except the broad ligaments and the peritoneum covering the fundus, the vagina is thoroughly irrigated. The broad ligaments are now to be ligated. An aneurism needle, curved on the flat and set at right angles to the handle, is threaded with a silk ligature and passed through the base of the right broad ligament a short distance from the cervix; this secures the uterine artery. Successive ligatures are then applied until the entire ligament is tied off. As each ligature is tied the included portion is cut free from the uterus. Having ligated and secured the right ligament, the left is treated in the same manner.

If there be an elongated body, as is often found in uterine carcinoma, great difficulty may be experienced in ligating the entire ligament upon one side without tying off and removing a portion of the ligament of the opposite side. By adopting this course the organ can be pulled down and the remaining ligatures easily applied. As the ligatures are being tied down the traction of the uterus should be relaxed. The uterus having been freed from its ligamentous attachments, the peritoneum is broken through and the organ removed.

After the uterus has been removed, it is the custom of some surgeons to close the opening in the vagina. I do not practice this. The cut surfaces approximate themselves, and further favor drainage if we simply pack the vagina and do not stitch.

### REPORT OF CASES.

Case I.—Mrs. C., aged thirty-five years, was admitted to the German Hospital with an extensive carcinoma of the cervix, which had recurred after a previous curetting and now demanded the removal of the whole organ. The patient was carefully prepared for operation, receiving several antiseptic douches daily for a few days, and also boric acid baths. The anterior and posterior walls of the vagina were carefully dissected up, and the uterus freed and its broad ligaments tied off in sections. The ovaries were removed with the uterus. Light packing of iodoform gauze introduced into the vagina.

The patient made an uninterrupted recovery, and was discharged in three weeks.

Case II.—A. B., aged forty years, and unmarried, was admitted to the German Hospital with the following history: For some time past she had been suffering from profuse uterine hemorrhage. Menstrual flow was excessive and painful. Diagnosis of carcinoma of the uterus was made, and total removal of the organ advised.

*Operation.*—The mucous membrane of the anterior vaginal wall was dissected up until the fundus of the uterus was reached. Treated posteriorly the same way. The broad ligaments were tied off in sections—four on either side of the uterus, which was now removed with the ovaries and tubes. Ligatures now cut short. A light packing of iodoform gauze was introduced into the vagina, and a pad placed over the vulva. The packing was changed on the fourth day; on the seventh day a slight odorous discharge was noticed, which disappeared on the twentieth day after operation. No signs of peritonitis.

The patient was discharged on the twenty-fourth day. Microscopical examination of specimen proved the correctness of the diagnosis—carcinoma in early stage.

Case III.—Mrs. K. G., aged thirty-five years, admitted to the German Hospital with a history of curetting at another institution for carcinoma of the cervix. At the time of admission a granular mass was found involving the entire cervix. She was again curetted. Six days later vaginal hysterectomy was performed.

*Operation.*—The cervix was drawn down by means of a tenaculum, and a silk thread introduced through both lips of the same. The anterior vaginal mucous membrane was carefully dissected up from the exterior surface of the uterus. The posterior surface was similarly treated. A small vaginal cavity complicated the enucleation considerably. After the uterus had been

freed of the vaginal mucous membrane, clamps were applied to the broad ligaments. The organ was removed by cutting between the uterus and the clamps. The part was irrigated with boric acid solution, and the vagina packed with iodoform gauze. An antiseptic pad was applied to the vagina. The clamps were removed on the fourth day. Recovery uninterrupted.

CASE IV.—Mrs. K., aged thirty-four years, admitted to the German Hospital with a granulating mass of the cervix. An attempt was made to curette the mass away, but it was found to be too extensive.

*Operation.*—The cervix was firmly held with a vulsella forceps. The anterior vaginal mucous membrane was dissected away from the uterus. The posterior surface was treated similarly. The broad ligaments were tied off in sections—three ligatures upon either side of the uterus, which was now removed; the vagina was irrigated and packed with iodoform gauze. The dressing was removed on the eighth day, the parts irrigated, and dressing reapplied. The patient made a successful recovery, being discharged upon the fourteenth day.

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### PERMANGANATE OF POTASH IN THRUSH.

Drs. Troitski and Karntski (*Gazzetta Degli Ospitali*, No. 6, 1894) regard the permanganate of potash as the most efficacious remedy in the treatment of thrush, in children. Besides application of an alkaline solution they also employ the permanganate locally in solution. A 2-4 per cent. solution of the bicarbonate of soda may be employed for alkaline irrigation, or in very grave cases a saturated solution of this substance. Besides this the physician should touch, two to three times a day, the affected spots with the following:

℞

| | | |
|---|---|---|
| Permanganate of Potash.... | 25 | (grs. iv) |
| Destilled Water.....30 | 0 | (℥j). |

Under the influence of this antiseptic the disease rapidly disappears.

### REMOVAL OF BONES FROM THE THROAT.

Dr. O. Schliep (*Wiener Medizinische Presse*, No. 13, 1894) in those cases where a fish-bone or any kind of bone has been swallowed, or is lodged in the throat, removal after cocainization and with the aid of the laryngoscope is impossible, recommends drinking some dilute acid in order to soften the fragment. This suggestion he obtained from the popular employment of vinegar in such cases in Germany. Experiments with vinegar demonstrated that small fish-bones are somewhat softened in fifteen to twenty minutes. Fragments of bone require a longer time, while small scales from shell-fish are softened in one to two hours. Besides vinegar he has also tried 1-5 per cent. solutions of hydrochloric acid, with and without pepsin. Its action is decidedly more energetic than that of vinegar, fragments of lobster's shells only excepted. As hydrochloric acid is a normal constituent of the gastric juice, it rather deserves the preference in rendering fish-bones, etc., non-injurious. It is employed as follows: In case that the bone is situated high up, a stick, around the end of which is rolled a tuft of cotton, is dipped into a 2 per cent. solution (fourteen drops to fifty gms. of water) of hydrochloric acid and repeatedly pressed into the folds of the pharyngeal mucous membrane. In case that it is lower, or if the bone has passed into the stomach, this same solution may be frequently drunk.

### PYOCTANIN INTERNALLY IN MALIGNANT GROWTHS OF INTERNAL ORGANS.

Dr. O. Maibaum (*Wiener Medizinische Presse*, No. 13, 1894) has tried this drug in the treatment of internal neoplasms of a malignant nature, in Prof. Wassliew's clinic in Dorpat, Russia. He administered it three times a day in doses of six cgms.

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

(one grain), in pill form or associated with belladonna as a suppository:

℞

| | | |
|---|---|---|
| Pyoctanin,.....o | 06 | (gr. j). |
| Extr. Belladonna,.....o | 02 | (gr. 1-5). |
| Cocoa Butter,.....2 | o | (grs. xxx). |

In a case of pronounced cancer of the stomach an astonishing result was obtained; the patient increased in weight, the vomiting and eructations ceased and his appetite reappeared. In another case where there were adhesions with the liver and metastases, improvement followed, but the patient soon left the clinic. Also in cases of carcinoma of other organs it was found to be of great service.

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CALOMEL AS A DIURETIC IN NEPHRITIS.

Drs. Dunin and Sklodowsky (*Wiener Medizinische Presse*, No. 13, 1894) of Warsaw, Poland, claim that the prevailing opinion that calomel, though a valuable, diuretic in heart diseases, is of no value in renal affections, to be unjustified. They have employed it in fourteen cases of acute and chronic parenchymatous nephritis without having seen the slightest trace of a harmful action. Amongst these there were two where caffeine was employed without success, and, in two others, the disappearance of the œdema could only be ascribed to the calomel. In five cases no diuresis followed its administration. It was prescribed in the following formula:

℞

| | | |
|---|---|---|
| Calomel.....o | 20 | (grs. iij). |
| Opium.....o | 01 | (grs. 1-5) |

Sufficient for one powder. Three per diem.

At the same time the patient should use a gargle of the chlorate of potash, and apply the tincture of iodine and nut-galls to the gums. The calomel was administered for three to four days in succession.

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LARYNGEAL PHTHISIS.

Prof. Cozzolino (*Gazzetta Degli Ospitali*, No. 6, 1894) recommends the insufflation of the following powder in the treatment of laryngeal phthisis:

℞

| | | |
|---|---|---|
| Powdered Iodoform..... 5 | o | (5j¼). |
| Powdered Phosphate Lime. 10 | o | (5ijss). |
| Powdered Boric Acid..... | 40-80 | (grs.vj-xij). |

Insufflate morning and evening, into the larynx.

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HYSTERIA IN CHILDREN.

Prof. Jules Simon (*La Sperimentale*, No. 5, 1894) in the management of hysteria in children, advises removal from their accustomed surroundings and family, a quiet life, and a tonic treatment. Antispasmodics, on the contrary, are indicated: valerian, belladonna, etc. The bromide of potash does not always give good results. Valerian is best administered in a decoction with 10-15 gms. (ʒiiss ʒiv) of the root in 200 gms. (ʒvjss) of water, reduced to one-half a glassful by boiling. Of the valerianate of ammonia a dessert-spoonful may be taken at ten in the morning and six in the afternoon. Zinc may be also employed in pill form. Opium is to be avoided as it favors constipation and decreases the appetite without restoring intellectual equilibrium. Preparations of belladonna, hyoscyamus, in doses of a cgm. (gr. ⅙) of the extract are useful especially in the visceral pains. Camphor, by rectal injection, may also yield good results. Iron is to be excluded for by attempting to cure the anæmia, one will cause excitement. It would be preferable to administer the sulphate of lime in the food in the summer and cod-liver oil during the winter. Electricity which would seem indicated has not given any decided results. The galvanic current has been frequently employed by him without success; an intense faradic current will only increase nervous excitement. Slight galvanic currents with moderate massage are the best. Nux vomica does not render any useful service; it is not the terminations of the nerves which are diseased, but the will; a temporary abdication. Hence the indications are to excite neither the brain nor the skin, and to employ, together with isolation of the patient, valerian, hyoscyamus, etc. The electric bath is warmly recommended by Sagretti, of Rome, in the hysteria of children. He claims beneficial results.

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CALOMEL SOAP IN SYPHILIS.

Dr. Watraszewski (*Przeglad Chirurgiczny*, Tom I. Zeszyt II) warmly praises a calomel soap in the treatment of syphilis. It is prepared by carefully mixing calomel with a potash soap in the proportions of 1:2 or 1:3. This soap possesses the important characteristics of mercurial salve and mercurial soap, besides the following additional advantages:

1. It may be employed in inunctions without requiring but very little time for its application—ten to fifteen minutes.
2. It is colorless and does not stain the linen.
3. It will not irritate the skin.

### CHRONIC GONORRHŒA IN THE MALE.

Dr. J. Funk (*Przeclad Chirurgiczny* Tom 1, Zeszyt III) regards chronic urethral catarrh of gonorrhœal origin as chronic gonorrhœa, even though the presence of the gonococcus cannot be demonstrated. In recent gonorrhœa of moderate intensity he recommends oil of sandalwood, with injections of-Ricord's mixture, alternating with injections of nitrate of silver solution (1:4000). In invasion of the anterior and posterior urethra he advises deep injections of a 1-2 per cent. solution every five days. In chronic superficial gonorrhœa of the anterior portion, he commences with an injection of nitrate of silver (1:4000–1:2000) alternating with bismuth (1:1000); in case of failure he applies locally a 2-3-5 per cent. every five days, during the intervals injecting Ricord's formula. In chronic gonorrhœa of the anterior urethra with profound alterations, metallic sounds or sounds coated with Unna's salve are of material benefit. Gonorrhœa of the posterior portion requires deep injections of a 2-3 per cent. solution of nitrate of silver and, in case of prostatic invasion, one should use, besides metallic sounds the cooling sound (Winternitz's), suppositories of the iodide of potash or of ichthyol, with the general treatment.

### SUFFOCATING BRONCHITIS.

Dr. Hutchins (*La Revue Medicale*, March 18, 1894) speaks highly of the bichromate of potash in suffocating bronchitis. He advises the following formula:

℞ Bichromate Potash,.....0 | 05 (gr. ¾)
Sugar Milk,.....0 | 30 (grs. v).
Water, Twenty teaspoonfuls.
Triturate.

According to Dr. Drysdale, of Cannes, the bichromate of potash has an elective affinity for the mucous membrane of the respiratory passages. This solution is generally well borne with the minimum dose of one mgm. (gr. 1/60) for a child of one year, and with oppression and suffocation a maximum dose of three mgms. (gr. 1/22) which may be diminished in case of vomiting. (This dose seems still too large, for being a powerful irritant to the stomach and secondarily to the kidneys, it is liable to cause vomiting and renal irritation.)

### HEMICRANIA.

In the (*Gazzetta Medica di Roma*, No. 5, 1894) the following formula is recommended in the treatment of migraine.

℞ Citrate Caffeine,.....1 | 0 (grs xv).
Phenacetine,.....2 | 0 (grs. xxx).
White Sugar,.....1 | 0 (grs. xv).
Sufficient for ten capsules.
One every three to four hours during the period of the attack.

# CORRESPONDENCE.

## LONDON LETTER.*

March 20th, 1894.

Affairs medical are very lively, just now, in this colossal city; though in a few days, with Good Friday beginning, the Easter holiday season opens, and with many of the principal schools there will be a vacation until the second week in May.

Numerous holidays is a characteristic feature of English life. These numerous breaks in the annual session, with the easy, slow methods of imparting and acquiring knowledge, partly account for the necessity of the present long course of five years before degrees are conferred; the generally conceded purpose or justification being with a view of reducing the output of graduates. There are thirteen medical schools in London, with six large general hospitals and an almost innumerable number of special and minor ones. It appears that the number of matriculants in all the schools is about the same this year as usual; but, it is interesting to note the very small average numbers of students who attend lectures or clinics. The writer, in his tour through most of the schools during session hours and the hospital clinics, in no instance saw more than twenty attend at one time. This paucity of attendance was especially noticeable at the clinics, which, though often held by notable teachers, would seldom have more than

*Special correspondence to THE MEDICAL AND SURGICAL REPORTER.

ten or a dozen present. The ubiquitous "grind" is in steady demand in this city by those delinquents who find themselves behind as the time for graduation approaches. He has a practical method of "cramming" and giving "tips" when the time for examination arrives, so that, with his aid, many may slip through who might otherwise fail.

Here antiseptics yet hold well their own. Operating theatres, as a rule, are well-lighted, heated and ventilated. It is curious to note how largely woolen materials are employed as substitutes for cotton. All bandages are made of wool, and, impregnated or simple, it is used largely instead of gauze in ribbon strips in packing. Wool is abundant and cheap in England, but apart from this it has many highly valuable qualities which render its use preferable to cotton fabrics. It is highly elastic, a good non-conductor, and, when deprived of its oleaginous elements, is highly absorbable. Lister's alembroth has the general preference as an antiseptic dressing. In a general way perhaps one would say that in England as in America, surgeons of the present day are not fully innocent of excessive cutting and of the needless performance of many operations. This complete suppression of sepsis provides a guarantee often liable to carry one to undue lengths and to use the knife when it would be infinitely better to act on conservative lines.

The general practice of operating indiscriminately on every type of non-strangulated hernia has been quite generally abandoned, and now few of those so-called radical cures are undertaken unless complicating elements are present.

There are many reasons why Americans should more generally stop at London for a post-graduate course than cross to any of the continental cities. Here there are shoals of clinical material; victualing and lodging are cheap and good; the language is common and the facilities cannot be easily excelled.

From the present outlook, the attendance from London to the International Congress at Rome will not be large. Teachers and others interested in medical school work find it very difficult to get away. Yet, it is said, that as the meeting occurs in holiday time there may be a much larger delegation from Great Britain and Ireland than would otherwise attend.

The general health of London during the past winter has been unusually good; and to a person going there from America, it would appear odd that any one should ail there who had enough to eat and was comfortably clothed, as the climate is so bracing and regular. But unhappily like all great cities, London has its full share of the destitute poor and dissipated. The average life of an Englishmen should exceed that of an American in similar circumstances, and, as a matter of fact, it does. It certainly strikes one as remarkable to see the very large number of very old men who are actively employed here. It appears that of the 21,528 "bus" and tram car drivers of London, 917 are over seventy years of age. Among the literary walks of life it is not uncommon to see men of eighty or ninety years, hale and hearty. Mr. Gladstone is approaching ninety, and is yet the possessor of an active mind, and the late Duke of Wellington, who lived up to eighty-two years, was said to have enjoyed robust health until the last year of his life.—*Un Voyageur.*

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## "Doc."

If it has been your misfortune to be called "doc," and if this recognition has become at all general among your friends you might as well move to some other place. A man may be called a thief, a liar and a dead beat, and yet he may prosper and live upon the fat of the land. But once let him be called "doc" and his professional success is at an end. We would prefer to spend a night in the station house, so far as its effect on our professional success is concerned rather than to have our friends notice our approach by saying, "There comes doc." If a man calls you "doc" you need never expect a penny from him for any professional services you could render. His answer is sure to be, "All right, doc, in a few days that will be all right." "Doc" means disaster. "Doc" is the culmination of all calamity. "Doc" is a catastrophe given at one stroke. "Doc" is the warning that we have reached the extreme limit of our usefulness. "Doc" is the hand which points us to the next town. Shun it, my young friend, as you would flee from a Kansas cyclone or a prairie-fire. Knock the man down who first dares speak it to you; and call upon the whole medical profession for vindication of your righteous deed.—*Nat'l Med. Rev.*

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SATURDAY, MAY 5, 1894.


## EDITORIAL.

### THE REVISED VERSION.

Heretofore, the REPORTER has purposely refrained from commenting upon the question of the revision of the Code of Ethics, because it believes the importance of the subject has been much exaggerated, and because, so far as the great body of the profession is concerned, the discussion is unprofitable, as in the settlement the profession at large has no voice, either directly or through duly authorized representatives. It is the current impression that the Code of Ethics is a system of rules established by, and binding upon the entire medical profession of this country. As a matter of fact it is no such thing. The Code of Ethics is a declaration of the American Medical Association and its provisions are obligatory only upon members of that association and upon such others as may voluntarily yield allegiance to the action of that body. Why its influence has extended so largely over the profession will appear later on.

That magnificent organization called the American Medical Association, is generally regarded as the representative body of the medical profession of North America. And so it is, in the narrow sense that its members are drawn from all parts of the continent and are representative of the *personnel* of the American profession. Strictly speaking, however, it is not representative, for it is not a body of delegates duly authorized and empowered by the profession at large to take any action or formulate any measure, the results of which would be obligatory upon all practitioners. Like any other organization, the Association has the right to make rules and regulations for the government of its own membership, and its action is in honor binding upon all persons holding membership therein. But its power stops short at that point. There are, in round numbers, one hundred and twenty thousand practitioners of medicine in the United States, while the total membership of the American Medical Association does not exceed, if it reaches five per cent. of the entire number. There are

social and physical peculiarities in America, which render impracticable a medical central organization representative in the sense that the British Medical Association is representative of the profession of Great Britain. It is true that a portion of the membership of the American Medical Association is made up of delegates from various medical societies in affiliation with the Association, but if such delegates possess any authority whatsoever to legislate—which they do not—their action could affect only the societies they represented. It would be unwise to assume that the majority of the profession is amenable to the regulations of the various bodies represented in the Association. But in addition to such delegates, a very considerable portion of the membership of the Association is made up of individuals, who, by no stretch of imagination can be considered representative of any save themselves. Thus the American Association, as at present constituted, represents only itself, and consequently can legislate only for itself.

This view of the situation is generally lost sight of in the more or less intense discussions, *pro* and *con*, that are being exploited in current medical journals. Why it so happens, and why the Code of Ethics exercises so strong an influence on practitioners who are not directly subject to its provisions, renders necessary a few words upon the code itself.

What is the Code of Ethics? We venture to say that not twenty-five per cent. of the medical profession can answer the question in detail. We doubt very much if two per cent. of the entire number graduating medicine in 1894, have any satisfactory knowledge of the subject, either from their own study, or from their teachers, or from information gained in any authoritative manner. If asked, most of them would state such an idea of it as they may have, to be, that it forbids, under dire penalties the concession of any virtue to exist in an "irregular," or holding any communication with such an one; forbidding partial or entire ownership in any patented instrument or appliance; the ownership, or use, or endorsement of a secret, or proprietary medicine; or indulgance in personal advertising. Perhaps some might include a few indefinite ideas of formal courtesies that should exist between physicians, but, as a general rule, the conception would be limited to the "shalt not's." On the other hand, those more familiar with the code, depending upon their point of view, may esteem it anything from the straight gate and narrow way leading to a medical Paradise—and few there be that find it—to something analogous to that patriotism which Dr. Johnson defined as "the last refuge of a scoundrel."

But the Code of Ethics is none of these. As it exists to-day it is a moderate, dignified and liberal expression of the best guiding principles drawn from the experiences and opinions of the best men among the profession and for a considerable time, the observance of which principles in daily life tends to conserve the harmony and unity of a body of men working with a common purpose toward a common end to the benefit of humanity. The present discussion of the Code of Ethics is brought about, not so much by a lack of elasticity of the principles of the code itself, as it is by deductions drawn from an inelastic interpretation thereof.

It will be observed that the code does not assume the authority of a statute law. At the farthest it pronounces certain practices, not necessarily immoral in themselves, when brought within the domain of medical practice to become reprehensible and derogatory to the dignity of the profession. But it does not provide any penalty for failure to observe its declarations, which are capable of a much wider interpretation than that almost universally given. When the code was formulated,

not one new principle was enunciated, not one new practice advocated, not one new condition deprecated. Every principle incorporated therein was common to the entire profession; existed before codification was thought of; obtains to-day with little reference to the written code, and will continue in force hereafter, whether or not the code is modified, or whether it exists at all. The code voices the beliefs of the profession; in no sense did it create them, and it does but little to sustain them. So far as morality is concerned, the code is observed by those who do observe it, not because it is *The Code* but because the principles embodied therein are governing principles with the individual; and where the belief and practice of these principles is not characteristic of the individual, the code is utterly powerless. Regarded as an expression of moral law alone, the Code of Ethics sinks into insignificance when compared with its fundamental principle as embodied in the Golden Rule. As a system of morality it is very inferior to the code contained in the Ten Commandments, together with the Golden Rule. It is because the Code of Ethics is an expression of the application to a particular branch of human endeavor, of recognized moral principles which obtain among men and not because it is the dictum of any association of men, that it is so generally regarded as binding upon the entire profession.

No claim is made that the Code of Ethics is essential to the development or progress of medicine as a science. Indeed, a primary condition for the advancement of science is, that it shall be free from artificial and arbitrary restraints.

A Code of Ethics is immaterial so far as the acquirement of a medical education is concerned, and finds no recognition in the medical curriculum.

The Code of Ethics is not regarded as a qualification for admission to the ranks of the profession. In so far as it has any definite influence, that influence is not exerted until a practitioner comes into contact with his fellow practitioners, and it would seem that the only occasions upon which the existence of the code becomes evident, are occasions when one practitioner, becoming dissatisfied with the conduct of another, hunts around for a moral scale with which to determine the obliquity of his neighbor.

There are many among the most enlightened and progressive, whose characters and abilities are glories of the American profession, who resent the idea that the medical profession is peculiarly in need of a written code of ethics. They believe, and are justified in their belief, that physicians require no hard and fast laws to define what is right and what is wrong, or anything more than that unwritten consensus of belief sometimes called public opinion. An incontrovertible proof that the abolition of a written code does not mean the abrogation of all sense of morality, or of courtesy, or of ability, and that the absence of a specified code does not entail a wild plunge into practices and conditions which that code would designate reprehensible, is furnished by the profession of the State of New York. The New York profession declined to permit the American Medical Association to dictate in matters of conscience, and, as in honor bound, withdrew from that association, declaring independence of any *written* code of ethics. No evidence is presented, as yet, that the medical profession of New York is less able, less courteous, less earnest or less effective, than is the profession in any other part of the country. Curiously enough, one can observe a constant stream of men from all parts of North America pouring into the centre of the New York profession for post-graduate study and for a chance to see all that is new and best in modern medical science. This is sufficient answer to those who pro-

claim that the Code of Ethics is the one bar restraining the profession from falling over itself in a mad effort to consult with irregulars, or to patent some device, or to seek notoriety through the public prints. As a matter of fact the controlling principles now in existence would remain undiminished in force if the code were utterly repudiated.

Although the idea of any interference with liberty of conscience is utterly repugnant to the American mind, and although every attempt to make regulations that will in any way curtail the freest exercise of the individual's rights to his own convictions of morality will inevitably fail, we are convinced that the *written* Code of Ethics has been and is of benefit to the medical profession. Undoubtedly it has been much abused. Misuse of the code has sometimes made it appear as an impediment in the progress of medical science, but wherever the code has been charged with obstructing progress or with involving the profession in an absurd position, investigation will show that it has not been by an application of the *principles,* which alone give value to the code, but by the misapplication of narrow and arbitrary constructions of the meaning of declarations, which themselves are second-hand deductions from the general principles premised.

The only value possessed by the Code of Ethics is (to quote the Proem of the Report to the American Medical Association) that of "an ideal code which is the crystallization of the best thought and sentiment of any considerable body of men who have for long periods been associated with a common purpose, with reference to the regulation of their conduct in their relations to one another and to society in general.

"Such a code forms an ideal standard, to the requirements of which each individual should strive to attain—a lamp to the feet of the young and inexperienced—a mirror into which the more mature, glancing, may be able to judge whether or not they are swerving from the paths of rectitude and honor."

But especially is it of value as a guide in questions of professional *etiquette*, for "by due conformity to its requirements the prosecution of affairs is facilitated, friction diminished, misunderstandings obviated and intercourse rendered more agreeable; it cannot be neglected by physicians any more than by other classes of society. The peculiarly delicate and personal character of the relations of physicians to their patients naturally involves conditions which call for especial provision in this respect."

Whatever may be the final action of the American Medical Association—and the Association is a powerful factor in moulding medical public opinion—it should never lose sight of the purpose of its existence, which is to *grow into* an organization of a truth representative of medical science in America. If it is deemed necessary to incorporate a declaration of ethics in the general statements of its purposes, it must make that declaration broad enough to include widely varying interpretations, the extremes of which equally may be held in good faith, and to permit of the free exercise of individual judgment as to right and wrong. It should be a medical republic from citizenship in which ethical faith should be no bar. The moment limits are placed upon the free exercise of individual thought and conviction, and the acceptance of a strict and invariable set of rules of conduct is made a qualification for membership that moment, by its own act, the Association ceases to be truly representative of medical science, in that it debars men who may be in every other way qualified and recognized. Only on the broadest possible platform can the American Medical Association achieve the purpose of its organization—a truly representative body of a united profession.

# ABSTRACTS.

## PERMANGANATE OF POTASSIUM AS AN ANTIDOTE FOR MORPHINE.

Dr. William Moor, (*N. Y. Med. Rec.*) writes: In offering to the profession a new intidote for morphine it is not my desire to speak of a new, heretofore unknown or unused chemical body; on the contrary, the substance which forms the subject of these lines is one with which every physician and pharmacist is familiar. The term "new antidote" simply relates to the fact that the substance in question had not previously been used for the purpose of antagonizing or, rather, destroying morphine, for I don't know of a single instance in which permanganate of potassium—$Mn_2O_8K_2$—has been used as an antidote for morphine.

I have paid a good deal of attention to the therapeutics of permanganate of potassium during the past year, thinking that such a powerful destroyer of organic matter should be more utilized in the treatment of certain gastric disorders that are associated with putrid fermentation of the ingesta, also in cases of cancer of the stomach to suppress the fœtor of the breath, which renders patients a burden to their surroundings, and came to the conclusion that its mode of administration was at fault, inasmuch as no one likes to drink a purple, "poisonous" looking liquid, and, on the other hand, if given in pill form, it would act as a caustic upon a very small part of the glandular lining of the stomach, thus causing distress without any beneficial result. After some trials I found that the best way of administering it was to have it made up in pills with cacao butter and talcum or kaolin, and to direct the patient to drink very slowly a glassful of water just one minute after taking the pill, for the latter begins to disintegrate in one minute at the temperature of the body. By using this method I successfully combated the extremely disagreeable odor in a case of cancer of the stomach. About that time I treated a well-known actor suffering from acute pleurisy. This gentleman was addicted to morphine, and as I had taken much interest in him, I earnestly sought the best plan to break his habit. The idea occurred to me that perhaps permanganate of potash might decompose morphine, the latter being an organic substance, and that by making use of a certain method I could eventually break this habit without restricting him from taking his morphine. My patient, however, started on a professional tour just when I began to put my idea to a test. This circumstance did not prevent me from continuing my researches as to the effect of permanganate of potassium on morphine, and to-day I am permitted to offer to the profession what I consider to be the antidote *par excellence* for morphine.

In the following remarks I shall give a brief outline of the experiments that led me to this conviction. Pouring a solution of one grain (0.06 gramme) of $Mn_2O_8K_2$ to one ounce of water (31 c.c.) into a solution of one grain of sulphate of morphine to one ounce of water, I noticed that this mixture did not for an instant assume the purple color of a $Mn_2O_8K_2$ solution, but at once formed a greenish liquid; and that after a few moments a dark precipitate would sink to the bottom of the test tube, leaving an almost colorless, tasteless liquid, in which the presence of morphine could not be detected. Knowing my great susceptibility to even very small doses of morphine, I could easily ascertain whether or not this colorless, tasteless liquid possessed any narcotic qualities. The road of safety being the best way, I began by taking a mixture of one-sixth of a grain of sulphate of morphine and one ounce of a 1 to 2000 $Mn_2O_8K_2$ solution. Under ordinary circumstances one-sixth of a grain of morphine has a profound narcotic effect on me, lasting for several hours; I, therefore, rarely have taken for analgesic purposes more than one-eighth of a grain. The above-mentioned mixture of one-sixth of a grain of sulphate of morphine and one ounce of a 1 to 2000 $Mn_2O_8K_2$ solution produced no effect whatever on me. Gradually I increased the amount of morphine, and correspondingly the amount of permanganate of potassium, until I took two grains of the sulphate of morphine in one dose with the same amount of permanganate of potassium in solution. The

results of these experiments, however, did not demonstrate that permanganate of potassium was an antidote to morphine, as it was quite possible that it might be deoxidized by the organic matter of the buccal cavity, œsophagus, and stomach, chiefly by the contents of the stomach, before it could act on the morphine. To gain certitude on this point I conducted a series of experiments, a synopsis of which is as follows:

1. A 1 to 2000 solution of permanganate of potassium in water was held in the mouth for fully five minutes, when it still had a dark-red appearance, approaching the characteristic deep purple color of a $Mn_2O_8K_2$ solution, although the tongue and the gums have become brown.

2. If we dissolve one drachm (4 c.c.) of the white of egg in one ounce (31 c.c.) of water, and to this add one drachm of a 1 to 250 solution of permanganate of potassium in water (one-fourth grain of $Mn_2O_8K_2$) the mixture will for a moment have a purplish color, and after stirring it for one minute will be of a reddish-brown color, and have a distinct taste of permanganate of potassium. After five minutes, on filling two test-tubes with this mixture and adding to one of them a small quantity of sulphate of morphine—this latter being an energetic deoxidizer of $Mn_2O_8K_2$—but adding nothing to the mixture in the other test-tube, the former mixture will at once become of a much lighter color (light amber) than the one without morphine. Even after thirty minutes this differentiation can be affected. Thus we see that it takes one drachm of the white of an egg at least thirty minutes to completely deoxidize one quarter of a grain of the permanganate. Now, I found that one quarter of a grain of permanganate will be deoxidized by exactly the same amount of sulphate of morphine in one second—for the sake of convenient calculation one moment may be considered as one second—therefore one drachm of sulphate of morphine deoxidizes one quarter of a grain of the permanganate at least seventy-two thousand times quicker than a drachm of albumen would do it, assuming that the latter could accomplish it in five minutes. But as we saw that the deoxidization was not complete after the elapse of half an hour, we are justified in saying that the chemical reaction between the permanganate and the salt of morphine is infinitely more rapid than the one between the former and the white of egg.

3. By substituting for the albumen one drachm of peptone, in the experiment just related, we find that one grain of $Mn_2O_8K_2$ is not completely deoxidized by one drachm of peptone in five minutes. Calculating in the same manner as before we come to the conclusion that the rapidity of reaction between the permanganate and the salt of morphine is at least eighteen thousand times greater than the one between the former and peptone.

Having gained the knowledge of these facts it is not surprising that I could swallow with impunity toxic doses of sulphate of morphine followed in a few moments by a corresponding amount of the chemical body which I was justified to consider the antidote *par excellence* for morphine. Thus, on one occasion, four hours after a full dinner, at a time when the stomach must have contained a great amount of soluble peptones and other organic matter, I took two grains of the sulphate of morphine in about half an ounce of water, followed in one minute by three grains of its antidote—for safety's sake one grain more than necessary—dissolved in four ounces of water. In another instance, on January 9th of this year, three hours after a light supper, I took, in the presence of several colleagues belonging to the staff of the West Side German Clinic of this city, three grains of sulphate of morphine, followed in about thirty seconds by four grains of permanganate of potassium, both in aqueous solution. I was perfectly confident that the antidote possessed such a wonderful affinity for the morphine that it would select it instantaneously from among the contents of the stomach, and thus render harmless what might have easily been a fatal quantity to one so susceptible as I am to even very small doses of this alkaloid. A striking demonstration of the astonishing selective faculty of $Mn_2O_8K_2$ for morphine can be shown by mixing two hundred and fifty grains of the white of egg with one ounce of water, dissolving in this mixture one grain of sulphate of morphine and adding to the whole just one grain of the permanganate dissolved in one ounce of water. After thoroughly mixing not a trace of morphine can be detected; which conclusively proves that the molecules of the antidote instantaneously selected the molecules of morphine

without being interfered with by the albumen, though the quantity of the latter so greatly exceeded the quantity of morphine.

The question arises, What becomes of $Mn_2O_8K_2$ and $C_{17}H_{19}NO_3+H_2O$ (morphine) after they have reacted upon each other? While it is easy to determine that the permanganate is deoxidized by the morphine with formation of manganese binoxide—$MnO_2$—manganate of potassium—$MnKO_4$—and potassium hydroxide—KHO—thus leaving $O_2$ for the oxidation of morphine, this latter undergoes changes, the nature of which I have not yet been able to determine, but hope to be able to do so in the near future.

In case of poisoning by any of the salts of morphia, ten or fifteen grains of the antidote dissolved in six or eight ounces of water should be administered at once and repeated at intervals of thirty minutes three or four times, or even more often. Permanganate of potassium, as well as the salts of manganese, are comparatively harmless even if given in large quantities. I have poured into the stomach of a rabbit weighing four pounds a solution of five grains of $Mn_2O_8K_2$ in two ounces of water, and one hour later two grains more dissolved in one ounce of water, without noticing any toxic effects whatever. One ounce of the sulphate of manganous oxide has caused only brisk catharsis (Dr. Thompson).

In cases of poisoning by the alkaloid itself or by tincture of opium (laudanum), also by opium, it is advisable to acidulate the antidotal solution with diluted sulphuric acid, or in the absence of this with some white vinegar (not red vinegar), by which the insoluble morphia will be at once converted into the soluble sulphate or acetate.

I have strong reason to believe that the administration of permanganate will be of beneficial effect even after absorption of the morphine has taken place. This statement I base on the following:

Professor Edward Hitzig,* of Halle, two years ago, proved beyond a doubt that morphine which was injected subcutaneously into dogs was secreted by the glandular lining of the stomach. Hitzig succeeded, by washing out the stomachs of animals that had received morphine subcutaneously, in obtaining fully one-half of the injected amount during the first hour after the injection. It is therefore a logical necessity that an antidote which acts instantaneously must destroy in the stomach a certain amount of poison that got into the circulation either through hypodermatic injection or through absorption by the stomach, for it is evident that the same circulation which conveys a poison from the peripheral parts of the body to the stomach, must also bring back to the latter a part of the poison which previously was absorbed by it. I intend to carry out a series of experiments upon animals to prove this conclusion; for the present I just state that some experiments for this purpose upon rabbits have been highly encouraging. As to the effect of permanganate of potassium upon other alkaloids, I shall briefly enumerate the results I have obtained.

*Atropine.*—One grain of sulphate of atropine dissolved in one ounce of water added to one grain of permanganate of potassium in half an ounce of water. Color, purple, as if the solution contained only permanganate of potassium. After four hours, color still purple, no change from original permanganate color; one drop instilled into a person's eyes widely dilates the pupils in a few moments; midriasis lasting over twenty-four hours. After eight hours, color dark red, taste intensely bitter; addition of sulphate of morphine gives the characteristic reaction (dark precipitate, colorless liquid above it). After twenty hours, color dark brown, taste intensely bitter; addition of morphine gives the characteristic reaction. Thus permanganate of potassium has practically no effect upon atropine.

*Cocaine.*—One grain of cocaine muriat. to one ounce of water added to one grain of permanganate of potassium in half an ounce of water. Color, purple, as if the solution contained only $Mn_2O_8K_2$.

Four hours later, color dark red, taste intensely bitter; one drop instilled into a person's eye causes decided midriasis lasting half an hour; addition of morphine gives the characteristic reaction. Eight hours later, color grayish red, taste bitter; applied to the pharynx distinct difficulty in swallowing noticeable; dark precipitate on the addition of morphine.

Practically no effect on cocaine.

*Veratrine.*—Two grains of veratrine muriat. to half an ounce of water added

*Berliner Klinische Wochenschrift*, No. 49, 1892.

to two grains of permanganate of potassium in one ounce of water. Color, purple. Ten minutes later, purplish red. Fifteen minutes later, dark brown; precipitate on addition of acetate of morphine. Thirty-five minutes later, precipitate with brownish liquid above, the latter turning light on the addition of acetate of morphine, and if applied to the nasal mucous membrane causing violent sneezing (one of the characteristics of veratrine). Useless in veratrine poisoning.

*Pilocarpine.*—Two grains of pilocarpine muriat. to two ounces of water added to two grains of permanganate of potassium in one ounce of water. Color, purple; after five minutes, still purple; after forty minutes, carmine.

After seventy minutes, color carmine; one drachm injected subcutaneously into a rabbit causes lachrymation, salivation, profuse perspiration, irregular, rapid breathing (160), three or four copious watery discharges.

After three hours, color still red; addition of morphine gives the usual reaction. Practically without effect on pilocarpine.

*Aconitia.*—Two grains of aconitine to two ounces of water + two grains of permanganate of potassium to one ounce of water. Color, purple. After stirring for two minutes, same color.

After two hours, color unchanged; half a drachm (2 c. c.) injected into a full-grown rabbit; animal restless in a few moments, turns his head to the side, makes rapid swallowing motions, salivates, is evidently nauseated; difficult, irregular breathing, tremor, opisthotonos; animal lies on its side, apparently *in extremis*, but after ninety minutes symptoms begin to abate.

After twenty-four hours, color still reddish purple. Dark precipitate by addition of morphine. No effect on aconitine.

*Strychnine.*—One grain of strychn. sulphat. to one ounce of water + one grain of permanganate of potassium to half an ounce of water. Color, purple; after five minutes, red; after fifteen minutes, dark brown, intensely bitter; after thirty minutes, same color, taste intensely bitter. Addition of morphine, black precipitate, colorless liquid above.

Could not be depended upon in strychnine poisoning, if the stomach should contain organic matter, which is the rule.

I now submit this paper to the unprejudiced criticism of the profession, and hope that my *confrères* will aid me in developing the ideas laid down in it. If my humble efforts should result in saving human lives, I should feel amply rewarded.

### Headache.

℞ Caffeini Citrat. } āā ʒi.
Ammon. Carb. }
Elix. Guaranæ ʒi.

M. Sig. Teaspoonful every hour until relieved.

—*Exchange.*

### For Dysmenorrhœa.

In ovarian neuralgia and dysmenorrhœa where opiates cannot be tolerated, the following will be found useful:

℞ Ext. Belladonnæ gr. 1·5
Ext. Stramonii gr. 1·5
Ext. Hyoscyami gr 1·4
Quinine Sulphatis gr. 1·2

Mft. pil. No. 1.

—*Steer.*

### Sciatica.

Sciatica and other neuralgias:

℞ Tinct. Aconit }
Tinct. Colch. Sem. }
Tinct. Bel. } āā equal parts.
Tinct. Actea Racem. }

S. Six drops every six hours.

—*Metcalf.*

### Hay Fever.

Dr. T. F. Sterling uses:

℞ Eucalyptol ʒi.
Glycerini ʒi.
Tinc. Opii ʒii.
Aq. Dist. q. s. ad ʒvi.

M. Sig. Use with atomizer three or four times a day. The complaint will be overcome in a few days.

### Fetid Diarrhœa in Children.

Dr. E. Tompkins (*La Semaine Medicale*) speaks highly of the following, in the fetid diarrhœa of children as an intestinal antiseptica:

℞ Calomel 10 cgms (grs. jss).
Sulpho-Carbonate of Zinc 15 " (grs. ijss).
Subnitrate of Bismuth 8 gms (ʒij).
Pepsin 2 " (grs. xxx).

Sufficient for twelve powders. Three per diem in a child of one year.

### For Bronchitis.

℞ Spts. Terebinthinæ ʒiij.
Acid Acet ʒiv.
Vitelli Ovi one
Aquæ Rosæ ʒiiss.
Ol. Limonis ʒj.

M. Sig. Apply morning and evening.

Aitkin extols this liniment very highly in bronchial diseases.

## FRAUDULENT MEDICAL INSTITUTIONS.*

Of the twenty-one more or less active diploma "mills" still in existence in the United States, as described in the Report on Medical Education, by the Illinois State Board of Health, the following are among the most noteworthy:

"*Chicago Correspondence University*," Chicago, Ill. Incorporated in 1885; re-incorporated in 1887. "*National University of Illinois*," Chicago, Ill. Incorporated July 25, 1889. These two institutions, incorporated by the same person, have had no existence as teaching bodies for purposes of medical instruction, but are operated solely for the sale of their so-called "diplomas." A "diploma" of this "National University," signed "F. W. HARKINS, Præses," and issued to THOMAS J. REDMOND, "*datum pridie Januarias, Anno Domini*, MDCCCLXXXIV," was offered for record by the said REDMOND in Logan County, Idaho, May 14, 1891. The discrepancy between the date of incorporation, 1889, and the date of the "diploma," 1884, has not been explained.

In September, 1892, the secretary of the "University," one RUDOLPH A. VAN ANGELBECK, "Lit. D. F. N. U.," wrote from Pella, Iowa, offering the degree of M. D. to a graduate of the Chicago Ophthalmic College. The following is an extract from VAN ANGELBECK'S second letter: "In case you are afraid your diplomas do not entitle you to the M. D. degree, apply at once for a Fellowship, remitting $30 for same. Our Fellowships entitle holders to *any* degree." VAN ANGELBECK was arrested and indicted in March, 1893, for misusing the United States mails in carrying on his sale of the degrees of the "National University."

In November, 1892, the HON. JOHN W. FOSTER, Secretary of State, forwarded the complaint of the Department of Justice of the city of Amsterdam, Netherlands, showing that "this 'National University of Illinois,' at Chicago, has been selling medical diplomas to foreigners who have not taken its courses." One "PROF. BLACKBURN, M. A., D.Sc., LL.D.," was the agent for sale in London, England,—"price, two guineas."

During 1893 it transpired that these "diplomas" were being peddled under representations leading to the belief that they were from the new University of Chicago. DR. GOODSPEED, Secretary of the Chicago University, has no doubt that the University is being injured by HARKINS and his "diploma mills," and "would like to see the matter thoroughly exposed everywhere, particularly in England and Canada."

"*Malok's Brood*."—During the past three years one JOHANN MALOK, of Chicago, has profited by the wide-open incorporation laws of Illinois to the extent of securing charters for a brood of fraudulent diploma-selling institutions ostensibly formed—according to the language of their articles of incorporation—"To instruct students in medicine and surgery and to give diplomas to graduates;" "to educate pupils in medical science, to graduate them and to issue degrees of M. D., and honorary degrees of M. D., and to issue diplomas as graduates of obstetrics for accoucheurs and midwives;" "to educate people in all branches pertaining to medical science and obstetrics, dentistry, hydrotherapeutics, magnetism, hypnotism, and in everything that is for the benefit of the human body; and to graduate in the same and to issue diplomas and all kinds of degrees and honorary degrees for the same in present or absent." This last quotation is the "enlarged object of the German Medical College," chartered by the State of Illinois, December 28, 1891, certificate of "enlargement" filed by the Secretary of State, July 14, 1892.

The first formed of the Malok brood was the "German College of Medicine and Obstetrics," charter granted February 19, 1891. Then the "German Homœopathic Medical College," charter granted December 8, 1891. Then the "German Medical College," charter granted December 28, 1891; and the "German-American Homœopathic Medical College," the "German College of Gynecology, Pædology and Obstetrics," the "German Academy of Physiatric Physicians," etc. These institutions have been repeatedly and publicly denounced as fraudulent by the Illinois State Board of Health and their so-called "diplomas" refused recognition. Nevertheless, they are legally incorporated under the laws of the State of Illinois.

[* Compiled for the *Journal of the American Medical Association*.]

Evidence of the sale of the Malok "diplomas" in Germany and elsewhere is being accumulated with the view of securing a repeal of these charters.

"*Indiana College of Medicine and Midwifery*," Indianapolis, Ind. Chartered in 1878 by one CHARLES P. HEIL, who, at the time the Illinois Medical Practice Act went into effect, was at the head of the "Northwestern College of Midwifery," in Chicago. His "college" was refused recognition, and he, himself, was denied a certificate by the State Board of Health. Being thus compelled to leave Illinois he removed to Indianapolis, where he started his "Indiana College of Medicine and Midwifery," attention to which was first called by PROF. AUSTIN FLINT, of the Bellevue, in a letter to the Secretary of the Illinois Board, April 9, 1890.

DR. FLINT inclosed a diploma of HEIL'S institution, issued March 12, 1890, and conferring the "degree of Doctor of Medicine and Midwifery" upon one ALEXANDER KUNTSLICH, by whom the diploma was presented to DR. FLINT for registration under the laws of the State of New York. Certificates of the institution were presented to the Illinois Board by midwife graduates, but were refused recognition, and HEIL'S subsequent career may be found under the title, "Ohio College of Obstetrics, Medicine and Midwifery" —*q. v. infra.*

HEIL also announced his Indianapolis institution as the "Department of Obstetrics, Indiana Eclectic Medical College," a college not recognized by the Illinois State Board of Health.

"*Ohio College of Obstetrics, Medicine and Midwifery*," Cincinnati, Ohio. This institution was originally located at Indianapolis, Ind., see "Indiana College of Medicine and Midwifery," *supra.* In 1889 HEIL, the projector, obtained a charter under the laws of the State of Ohio, and began operations in the city of Cincinnati. In 1891 he was reported in the *Medical and Surgical Register* of the United States as living in Covington, Ky., "Dean of the Faculty of the Ohio College of Obstetrics, Medicine and Midwifery, Cincinnati, Ohio." The so-called "College" never had a local habitation or existence—a name only, under which to issue diplomas.

After leaving Illinois, HEIL was "graduated" upon one term of lectures by the Eclectic Medical College of Indiana, an institution not recognized by the Illinois State Board of Health. He appears in the current *Medical and Surgical Register* of the United States in capital letters as:

"HEIL, CHARLES P., A.M., Ph.D., (Ecl.), Ind. Ecl. Med. Coll., Indianapolis, Ind., 1883; Late Prof. of Obstetrics in Ind. Ecl. Med. Coll.; Surg-Steward in the U. S. Navy and Hospital Steward U. S. Army, Late War; Mem. of National and Ind. State Ecl. Med. Assn's; Examining Surg., The Brotherhood of Railroad Trainmen; Late Dean of the Ind. Coll. of Med. and Midwifery, Indianapolis, 1696 3d av., New York, N. Y."

"*Vermont Medical College—the Second Medical College of the American Health Society*," Rutland, Vt. This institution has no existence in Rutland, Vt., except on Commencement day, when one GEORGE DUTTON, of Boston, Mass., who comprises the "Dean and Faculty" of the concern, takes his "graduating class" from Boston to Rutland and there holds "graduating exercises" and issues his diplomas.

DUTTON first attempted to organize what he styled the "First American College of the American Health Society," in Boston; but the Massachusetts Act of 1883, forbidding corporations created under the general incorporation laws from conferring degrees in medicine, secured through the exposure by the Illinois State Board of Health of certain bogus "diploma mills" in Boston, frustrated this attempt. He then incorporated this "Second Medical College" at Rutland, in 1883, under a Vermont act authorizing the creation of corporations to establish and maintain literary and scientific institutions.

Although his "diplomas" are issued in Vermont they do not entitle their possessors to practice in that State, the Supreme Court having decided, in the case of one of DUTTON'S "graduates" against the State Board of Censors, that such institutions are not empowered to confer degrees or issue diplomas. DUTTON gives "instruction" in Boston, and has issued some forty-five or fifty Vermont "diplomas" on which persons are practicing medicine in States which recognize "diplomas or licenses from legally chartered medical institutions."

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FOGG—Come, Figg, have a smoke.

Figg—I'll die first.

Fogg—Oh, well, every man to his liking. I'll do my smoking before I die.—*Boston Transcript.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

THE VIRGINIA MEDICAL MONTHLY for April. Dr. J. W. Long contributes a paper on

**Hysterectomy for Fibrous Tumor, Complicated with Pregnancy,**

reporting a successful case. After reviewing the dangers of pregnancy in a uterus which is the site of a fibroid tumor, the author presents the following propositions:

1. Never fail to advise a woman, the subject of a fibroid, of the dangers of pregnancy.
2. Cervical fibroids, whether submucous or interstitial, should always be enucleated if within reach.
3. Subserous fibroids that have small pedicles may be let alone—trusting that they will be pushed aside, and will not take on such rapid growth.
4. Small or medium-sized tumors, that show no special disposition to rapid growth, may be let alone.
5. Large tumors, especially when multiple or interstitial, demand operative interference.
6. Abortion or induced labor are hardly justifiable.
7. Cæsarean section is rarely indicated because of the high mortality.
8. Myomectomy may be practiced in some instances, when there is only one large tumor, and it is situated on the fundus and does not have too broad an attachment to the uterus.
9. When the tumor has a broad attachment, or is situated near the tubes, supravaginal hysterectomy is indicated.

In the instance reported by the author, the woman, a negress, was about three months pregnant. At the operation the ovarian and uterine arteries were ligated and cut, and without any pedicle ligature the tumor was cut away at the internal os. The pedicle was trimmed, the canal cauterized with carbolic acid, superimposed plains of silk sutures applied, and the stump dropped. The peritoneum was carefully sutured on either side, the pelvic cavity made thoroughly dry with sponges, and the abdominal wound closed without drainage. The patient recovered without the slightest drawback. The author states that unless some one else can produce a case ante-dating his (December 26, 1893), he may claim to be the first surgeon in the South who deliberately did a hysterectomy for fibrous tumor complicated with pregnancy. And, possibly, the first one in America to suture and drop the pedicle.

In this issue appear two papers on puerperal eclampsia. The first is from the pen of Dr. W. P. C. Hazen, entitled

**Observations on Puerperal Eclampsia**

with the history of a case. After reviewing the opinions of the various authorities as to the causation, he comes to the conclusion that it is caused by uræmia produced; first, by the pressure of the gravid uterus on the abdominal aorta, its primary branches and the inferior vena cava; second, obstruction to the outflow of urine; and third, the additional burden imposed upon the kidneys, through their excretion of urea, from the fœtus.

In regard to the treatment he states that it is his opinion that in all obstetrical cases in which the physician is consulted, be it early or late in the period of pregnancy, if his slightest suspicion is aroused in regard to the action of the kidneys, he should lose no time in examining the urine. Should we discover albumin, prophylactic treatment is our first thought.

In this line, the very best effects have resulted from the enforcement of a strict milk diet. In those cases in which it is impossible, the diet should, at least, be restricted; in short, the same dietetic treatment is indicated as in true Bright's disease. The physician should see to it that no pressure results from the clothing, and in all cases corsets should be thrown aside. Where it is practicable, in cases of primaparæ, the medical adviser should explain to the husband the ill effects of excessive venery. As to medicinal treatment for prophylaxis, diuretics and saline cathartics hold the first place. Simple bi-tartrate of potash, or a mixture of the bi-tartrate of potash, and infusion of digitalis, make the most valuable diuretics that he knows of for these cases. The tincture of the chloride of iron should be kept up continuously and in generous doses. During the period of prophylactic treatment, special attention should be given to the stomach, and attacks of indigestion should be promptly dealt with.

If nervous symptoms develop, active measures should at once be resorted to. To relieve the severe cerebral symptoms which precede convulsions, and to ward off the convulsions, venesection is undoubtedly the surest and quickest means. He has also used, with good results, elaterium, croton oil and pilocarpine. Hypodermic injections of morphine, in conjunction with any of the above remedies, afford good results.

In regard to the premature emptying of the uterus, he thinks that in certain cases it is undoubtedly justifyable; but his own practice in this respect is the conservative one, of letting nature take her course Labor is generally precipitated by the convulsions; the uterus emptying itself spontaneously.

The second paper on the subject is by Dr. Ralph Davis, "Twenty Years' Experience with Tincture of Veratrum Viride in the Treatment of Puerperal Convulsions." The author administers the drug in doses of twenty-five to thirty drops hypodermically, and claims that it will control puerperal convulsions, when administered in large doses, and that it is perfectly safe to administer it in sufficient quantities to control any case of convulsions. His experience with it has convinced him that it is both safe and efficient. He has used tincture of veratrum viride in

the treatment of every form of conclusion, except traumatic tetanic convulsions.

Dr. Johnson Eliot contributes a paper on

**Foreign Bodies in the Upper Air-Passages.**

Under ordinary circumstance, he says, foreign bodies in the upper air-passages are arrested in well-recognized localities, among which are the pyriform sinus or fossa, situated laterally to the larynx and the sulcus between the tongue and epiglottis. Usually no trouble is encountered, but an epiglottis which lies close to the tongue or has a wide rolling crest, may have to be forced back before a clear view is obtained.

When lodged in the larynx, the body is easy of recognition by reflected light—arresting spasm by chloroform; a solution of cocaine hydrochlorate is also useful. In some cases, a view is obtained of the trachea to its bifurcation, and in one of his cases a considerable portion of the right bronchus was seen. The recesses about the palatine folds, the post-nasal fossa, and the tonsils, also afford places of lodgment of foreign bodies, but here, with manipulation, they are easily seen.

There is scarcely a point in the throat or nose which cannot be viewed, and any adventitious substance removed.

The author does not look with favor on the practice of swallowing large quantities of bread, potatoes and substances forming a large bolus, as he believes by so doing the point of the pin or bone swallowed is likely to be forced deeper into the tissues.

Dr. A. R. Shands discusses

**Tubercular Osteitis of the Hip-joint,**

presenting an analysis of 158 cases illustrating its three stages. Hip-disease, especially in children, follows a distinct type, which is to-day classed as a degenerative tubercular osteitis. It presents itself in whatever joint it appears in much the same form, affecting the spongy tissue of the epiphyses, most often near the line of junction with the shaft. It may begin as a single or multiple focus of tubercular degeneration. Later in the history of the affection, the nodule breaks down into pus; generally, the original focus is surrounded by smaller tubercles, which aid in its extension, but the chief mischief is done by the rarefying osteitis. At this stage of the diseased process the focus may be absorbed, and so cured; it may extend to the periphery of the bone and break through and empty itself there; or it may extend into the joint, by far most common, and infect that. When the diseased focus is not absorbed, the most favorable course is for it to break through the periosteum and discharge into the periarticular structures.

In regard to prognosis, he states that the large majority of cases tend, under favorable circumstances, to recovery with more or less deformity; hence it becomes the surgeon's duty to see that the chances of recovery are as favorable as possible, to use the best means of preventing the deformity, and, at the same to get the most useful limb.

As to treatment, the indications are to furnish fixation, extension and protection; to benefit the patient's health in every possible way; to prevent and correct deformity, and to meet such complications as may arise. For the purpose of fixation, the writer prefers the plaster-of-Paris spica to anything that he has ever seen used. In applying it two assistants are necessary to keep up gentle traction on the diseased limb while the dressing and plaster bandages are being applied, which should extend from the lower border of the axilla to the tips of the toes; traction should be kept up until the plaster is well set. If the dressings and plaster are snugly applied around the processes of the ilium, the condyles of the femur and the malleoli and foot, no motion is possible at any of the joints of the encased limb. The spica should be reinforced by pieces of light steel extending from the free ribs to middle third of femur. If there is more deformity than can be overcome by gentle traction at first sitting, put the limb up in line of deformity after being partially corrected. Within a short time the muscular spasm will be sufficiently overcome to allow the limb to be brought into proper position, when a second spica can be applied. The complete immobilization thus secured will in large majority of cases overcome in two or three months the muscular spasm, sufficiently to admit of the application of the long traction splint. The walking brace should not be applied until the muscular spasm has been sufficiently overcome to reduce the deformity, so that when the patient walks the traction exerted on the leg by the brace shall be in the line of deformity. It should be continued just as long as there is any spasm remaining and until all signs of disease have disappeared.

In regard to the treatment of abscess, the author advises to let it alone if it is not causing constitutional disturbance. If the abscess is increasing rapidly and there is danger of its burrowing into the tissues, aspirate it, then strap it with basket strapping and a roller bandage over it. In regard to excision, he regards it as only justified as a *dernier resort* in the early stage and only when there is reason to think that there is more extensive osteitis than nature can relieve itself of without risk of a fatal complication arising during a long-continued suppuration that will necessarily follow. The author urges the importance of making an early diagnosis; of improving the patient's health in every possible way; of protecting the joint by mechanical means just as soon as spasm is recognized and continuing it just as long as any spasm remains; then he believes very few abscesses will result and rarely ever will there be any necessity for an excision.

Dr. James D. Morgan presents some "Remarks on Typhoid Fever." He believes that calomel, judiciously managed in the prodrome and the first days of the stage of pyrexia, has a salutary effect in shortening the duration of the disease. He has seen good effects from veratrum viride when cold sponging had little quieting effect.

Dr. Joseph Jones presents a

**Contribution to the Natural History and Treatment of Diphtheria**

in the United States, and more especially in

New Orleans, Louisiana. He closes his paper with the following report of the committee of the American Medical Association, made twenty-eight years ago, which he sees no reason to differ from even now.

*1. That diphtheria has occurred as an epidemic from time to time from the first settlement of this country.*

*2. That it is a distinct disease, on no account to be confounded with scarlatina or croup.*

*3. That it is particularly a disease of childhood, although it exempts no age.*

*4. That it is communicable to that degree that it is the duty of every physician to separate the infected from those that are well, particularly in children.*

*5. That it is a disease primarily affecting the blood; consequently the treatment to be effective must be local and general, and of such a nature as to eradicate or neutralize the poison; such local treatment should, however, be used as will prevent the absorption of the fluid portions of the exudation.*

*6. When the exudation has invaded the trachea, the only hope of saving the patient is tracheotomy*

Dr. John F. Moran discusses the "Antagonism of Erysipelas in Disease." The antagonism is due, in his opinion, to the antitoxine secreted by the bacteria.

The remaining papers in this issue are: "Need of Care in the Diagnosis of Spitting Blood," by James D. Morgan, M. D., and a clinical report of a case of "Induction of Premature Labor in Contracted Pelvis," by E. S. McKean, M. D.

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THE SANITARIAN

for April contains an article by Dr. A. Walter Sinter, on

**State Sanitation,**

particularly in regard to diphtheria and its diagnosis. The author writes of the Klebs-Loeffler bacillus, and the fact that no case can be declared true diphtheria if this bacillus has not been found in the secretions from the lesions. The physician usually cannot promptly examine, bacteriologically, the membrane found in the throat of a patient, and as it is of great importance to the community that this should be done by some one, the various boards of health should arrange laboratories to have all cultures submitted to them by physicians, examined at once, and should notify physicians to make, and promptly submit these cultures.

In New York the system has been put in practice, and the only obstacle now is the very small appropriation given the Board of Health to carry out its work.

In the same number an article from *Engineering* refers to "Dangerous Occupations," and those involving the handling of carbonate of lead particularly.

Means for rendering these less dangerous to the workman are pointed out, and also the fact that as it would involve some extra trouble, and even a little discomfort for the workers, they stand opposed to measures intended solely for their benefit, and the workers prevent the improvements more than the employers, who would feel the changes suggested very decidedly in the greater expenditures made necessary.

Dr. William Paul Gerhard writes about the

**Modern Rain-Bath.**

The article refers to the shower-bath, compared to the tub-bath, in schools, factories, barracks, etc.

Where many persons are to use the same apparatus it is important that it shall work rapidly, effectively, take up as little room as possible, and consume as small a quantity of warm water as possible.

These objects seem to be gained by the use of the inclined shower, in preference to the ordinary tub. Figures are given to show the relative amounts of water, etc., required, and the author claims that the bath has the additional advantage of toning the system instead of leaving the bather in a languid condition, as a warm tub-bath usually does.

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THE BRITISH JOURNAL OF DERMATOLOGY

for March. Dr. Stephen Mackenzie writes about

**Urticaria,**

which he believes to be due to some irritation of the nervous plexuses supplying the skin caused either by some poison absorbed, as in the case of ruptured hydatid cysts, or by some poisonous food, as mussels. Or it may be reflex as seen in some cases of gastritis.

Several cases are detailed showing the different appearances urticaria may present in different persons.—Urticaria hemorrhagica, presenting large patches resembling bruises, and a dark band encircling the abdomen, while at the same time wheals were to be seen on the extremities—this case, the author thinks, a manifestation of hemorrhagic diathesis, and not a distinct form of urticaria. Another case was mentioned where a patient had suffered, in spite of treatment, from urticaria of ten or twelve years standing. In a case of urticaria pigmentosa, patches of buff colored skin were found over various parts of the body, and these became so irritable, on exposure to the air, that the patient began rubbing and scratching, causing the appearance of wheals, papules, etc.

Giant urticaria is another division, and under this head is mentioned a case where the eruption was so great, and also occupied so much space, that a diagnosis of erysipelas was made—the slight constitutional affection, and the short time it lasted, and the presence of more characteristic spots elsewhere, made the diagnosis plain.

The opinion of Sir Andrew Clark, that asthma is really due to urticarial swelling, and not to spasm of the bronchioles, is mentioned.

The author's favorite treatment seems to be antipyrin, in twenty or thirty grain dose at bed time, and the external use of a solution of glyceride of lead (in water one part to 20) salicylic and carbolic acid ointments are also mentioned, and among internal remedies; salicylates, colchicum, bromide of poatsh, and

pilocarpin. Although having had some success with pilocarpin, the author also advocates atropine in doses of 1-120 to 1-100 grain.

Dr. Henry Handford describes a case of

**Dermatitis Exfoliativa Pigmentosa.**

The patient was a gray-haired man of 55 years, formerly with light complexion, but now of almost the color of a Hindoo, or mulatto, without having any symptoms of Addison's disease. The only complaint is of itching and irritation of the skin; which is found on examination rough, scaly and somewhat indurated.

One day in summer, thirteen years ago, he scratched his leg, while mowing and very much heated, and it became inflamed and remained so ever since, at intervals. The inflammation spread to the other leg, and when working and perspiring large blisters would form on the buttocks, dry, and peel off. In 1893, during hot weather, the eruption spread to arms, face, and trunk, and the pigmentation began, the groins and axillæ becoming darker than the trunk.

Shortly before admission to the hospital, he says, a large double handful of scales could be daily collected from his bed, but during his stay this was much less.

The condition resembled argyria, somewhat, but there was no history of the use of silver salts; the mucous membranes were not affected, and the coloration has diminished of late. Arsenical coloration is not usually so intense or universal, but the author says the color was similar in a case which he has described. The quantity of arsenic taken by this patient is thought to have been small (liquor arsenicalis in five minim doses from September 2d to October 20th.)

The treatment the author used was quinine, warm baths, and a solution of gelatine painted on the affected parts and covered by gauze bandages. Under this the skin became softer and moist, desquamation ceased but the pigmentation was unaltered.

Dr. John T. Bowen describes an

**Epidemic of Alopecia Areata,**

which he had an opportunity of seeing and which has been previously mentioned elsewhere.

The epidemic occurred in an institution, and of sixty-nine children, inmates, sixty-three developed the disease. Microscopic examination of hairs from the margins of the patches was made in numbers of cases; but nothing could be found to indicate tinea, no broken hairs, no scales, etc., no parasitic growth. Bits of skin could not be obtained. The only peculiarity found in this group of cases was that many had a large number of lesions so small that it was difficult to determine that any existed. Four girls of fifteen and over, and all the matrons and adults, escaped. The cases improved, but different varieties of treatment seemed about equally beneficial, and the child first affected, although not more severly attacked, appeared to be the last to get well.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE

### Treatment of Chronic Heart Valve Disease.

Dr. James Tyson (*Amer. Jour. Med. Sci.*) points that relief is often obtained from the occasional use of pergatives—five to ten grains of blue mass, followed by a saline, or the continuous use of small doses—one-half to one grain thrice daily. The greater apparent effect of the infusion of digitalis is due to its use in larger dose, although it is likely to be better borne by the stomach. Strophanthus, better borne by the stomach, has been used in doses of ten minims every two hours for forty-eight hours without interruption. Caffein in three-grain doses every three hours, in mitral regurgitation, is admirable, but is likely to produce insomnia. Sparteine in one-quarter, increased to one-half grain dose, three to five times daily, is of value if a diuretic be desired. For irregularity of heart action and palpitation, more common in mitral disease, belladonna is very useful. A belladonna plaster placed over a palpitating heart is a most efficient agent. Nitroglycerin, one-hundredth of a grain, increased to double the quantity, three times daily, often serves to the same end.—*Med. Standard.*

### The Treatment of Biliary Calculi.

M. A. F. Plicque (*Gazette des Hopitaux*) gives the treatment of this condition as follows:

1. With regard to the pain it may be regarded as of two forms: (*a*) Violent attacks of pain. In this form, apply very hot poultices with laudanum in them. Internally, gtt. xx. to xxx. laudanum, ext. opii and belladonnæ in gr. 1-6, every half hour till relieved. Sometimes inhalations of chloroform have been resorted to. (*b*) There is another form of pain that recurs from day to day, but is not so violent as the above type. This form is best treated by the use of narcotics, prolonged hot baths, revulsion over the liver by leeches in strong subjects, and a milk diet.

2. The means for the expulsion of the calculi are numerous. Some have tried and vaunted the use of ether; others glycerine; some again have found benefit [illegible] salicylate of soda. This is specially useful in angiocholitis. The best agent for the expulsion of these calculi is olive oil. This is usually well borne. When there is much revulsion to its use, the stomach tube should be employed.

3. The treatment in the interval. The best agent still is the olive oil. Alkaline waters are useful. Durande's mixture of essence of tur-

pentine 10 parts, and ether 15 parts, in quantities of 2 to 4 grams daily. Chloroform water relieves the flatulent dyspepsia in these cases. If there is any evidence of angiocholitis, salol ought to be administered. This is the best biliary antiseptic we possess.

4. The hygienic treatment must be kept in mind. Proper exercise is of value in restoring the balance of health.

5. Dietary. This should be plain. Abundance of water is indicated. Light, white wines are the only forms permissible. No heavy or indigestible food should be taken. Fresh fruits and vegetables are proper elements of the diet.

6. Medicines. Alkaline waters, as vichy, etc. Laxatives should be used, but strong purgatives should not be employed.

### A New Method of Politzerizing.

Every one who has tried it knows how difficult it is to get the patient whom it is intended to "Politzerize" to swallow at the proper moment. Under these circumstances, and as this plan of clearing the Eustachian tube is just now very much in vogue, our readers may be glad to know of a novel and vastly more simply way of attaining the object in view. In Politzer's method, as is well know, in order to prevent the air insufflated into the nose from escaping through the pharynx instead of passing into the tympanic cavity, the patient is asked to sound certain vowels or to swallow a mouthful of water, because in uttering certain vowel sounds, and during the act of deglutition, the soft palate is applied to the posterior wall of the pharynx. The naso-pharyngeal cavity, however, is only partially excluded by these means, and that for a very short time. Dr. Roydan therefore suggests that the patient be directed to take a deep inspiration and then to blow out the air through a small aperture between his closed lips So long as the patient blows the velum palati remains in contact with the posterior wall of the pharynx, and Politzerization can be performed without the slightest difficulty.—*Ex.*

### Marriage, Dysmenorrhœa, and Hysteria.

Wythe Cook (*Am. Jour. of Obstet.*,) finds from experience that in most cases of dysmenorrhœa and hysteria amongst single women marriage aggravates the disease. Hysteria is by no means cured by marriage, dysmenorrhœa often returns after pregnancy. One patient suffered from very severe dysmenorrhœa. She married, on advice, but the disease was aggravated by coitus. Conception occurred, and she fully believed that pregnancy would cure her, but the menstrual pain returned immediately after weaning. Another patient, subject to dysmenorrhœa, married when 20, and became pregnant when over 23. She bore a healthy child, and then took to the morphine habit. Her husband died a few months after her confinement. The period was suppressed for five years. After she ceased to take morphine it reappeared, at first irregularly, and at length in due season, but in both cases there was severe pain. She married again, and has remained eighteen months sterile; the dysmenorrhœa continues. A young woman subject to headaches and hysterical manifestations attended with hallucinations and depression got married. The neuroses were not improved by marriage. A robust young lady free from hysteria married, and bore two children within twenty-one months after marriage. Hysterical swoonings occurred during the pregnancies. A patient subject to dysmenorrhœa and hysterical fits married and bore five children. The menstrual pain never reappeared after the first pregnancy, but the fits still occur.

### Enteric Fever; Perforation; Peritonitis; Recovery.

Newton (*Chicago Med. Rec.*) has reported the case of a lad, 17 years old, who came under observation on the third day after having taken to his bed, with diarrhœa, tympanites, and pain in the right iliac fossa. The temperature was elevated and rose spots were present upon the abdomen. Restriction of the diet to milk and beef-tea, and the administration of a mineral acid and pepsin, and bismuth, salol, opium, were followed by amelioration in the symptoms. On the seventh day, however, the temperature again rose, the pulse became accelerated, small and thready, the face pinched, the skin cold and clammy, the tongue dry, and the abdomen tympanitic and extremely sensitive. It was learned that during the previous night, while a movement of the bowls were taking place, sharp, acute pain was felt in the side. Perforation of the bowel was diagnosticated, and celiotomy advised but not acquiesced in. Morphin, strychnin and whiskey were repeatedly administered, and by the following day the patient had rallied somewhat. He remained in a precarious condition for several days, when he gradually began to gain ground. For the succeeding three weeks the temperature pursued an irregular course and the diarrhœa was particularly obstinate. After the lapse of another week indications of the presence of an abscess between the anus and the scrotum appeared, and three ounces of fetid pus was evacuated. Through the opening made a probe could be introduced into the abdominal cavity for a distance of ten inches. The opening was kept patulous by means of gauze, which was removed after the lapse of twelve days, and the external wound was permitted to heal. From a few days after the occurrence of the supposed preforation complaint was made of a particularly sore spot, about three inches in circumference, below and a little to the left of the umbilicus, and over which percussion yielded a dull note. It is believed that the spot indicated the situation of the local peritonitis that existed, and which remained local from the formation of intestinal adhesions as a result of the exudation of plastic lymph. As peculiar features of the cases are pointed out the early date of the occurrence of perforation, the situation in which the abscess pointed, the failure of the temperature to decline, and the absence of vomiting.

### A Certain Sign of Death.

Mons. W. Necati (*La France Medicale*) reports to the Academie des Sciences the results of his experiments with a new instrument he has had constructed for the purpose of testing the ocular tensions. He has found that during life, tension varies from 14 gram. to 25 gram. Within half an hour after death, this tension has fallen from 1 gram. to 3 gram., and in two hours after death has become complete. As soon as the pulse ceases, the ocular tension falls, and steadily declines for two hours. An eye that has been enucleated and replaced in the orbit acts in the same way. By the time the loss of tension is complete, the body must have been dead at least two hours.

## SURGERY.

### The Principles of the Treatment of Gonorrhœa.

Professor Neisser, the distinguished discoverer of the gonococcus considers that all rational treatment directed towards the cure of gonorrhœa should be based upon the recognition of that micro-organism as the pathogenic principle of the disease. The greatest difficulties encountered in its eradication are that it does not remain localized in the urethra, but spreads to the cord, epididymis, prostate, and bladder in the male; to the uterus, tubes, ovaries, and peritoneum in the female; and that the virus in the later stages is situated deep beneath the epithelial layers, extending thence to the surface or deeper tissues, thus forming a chronic source of infection. It can only be easily reached in the first stages. The aim should be to prevent an invasion of the deep urethra and not to allow the disease to become chronic.

Treatment should be begun as soon as possible. The substances used must be (*a*) such as will kill gonococci, (*b*) which increase the inflammation as little as possible, (*c*) which do not injure the mucous membrane. Such are nitrate of silver 1-4000 to 1-2000; ammon. sulpho-ichthyol., 1-100; weak Rotter's pastilles, free from carbolic acid and mercury, 1 pastil to 250 of water; bichloride of mercury, 1-30,000 to 1:20,000. Pure astringents in the early stage are unsuitable, as they may serve to spread the infection. Cauterizing solutions of great strength, which may cause stricture, are dangerous, as are also most mechanical methods, such as the endoscope, bougies, etc. The best treatment is the early and frequent antiseptic irrigation of the urethra. For practical reasons, viz., the wide spread of the disease, injections with large syringes must generally be used instead of irrigations.

In the female the treatment should consist of thorough mechanica cleaning of the urethra and cervix, also using douches and injections.

The general dietetic, hygienic, and antiphlogistic measures are useful, and should be employed as far as possible. In all cases not very acute the presence of a posterior urethritis should be recognized and treated locally if an examination discloses the presence of gonococci. The treatment should not be limited in duration, as the aim should be not rapidity, but certainty. In chronic cases it should be determined if the discharge is infectious, and if it is so it should be treated by irrigations or instillations. If it is simple we must be guided by the pathological and anatomical changes in the mucous and submucous membrane as to the line of treatment it is best to employ. For the most part these cases require no treatment at all. When the deeper tissues are affected, sounds, instillations, the endoscope, and massage should be used.

The successful treatment of gonorrhœa in the female is attended with much more difficulty than in the male, and without frequent microscopical examinations judgment as regards the therapeutic result is impossible. Treatment should be begun as soon as possible and followed up most energetically, as the tubes, uterus, ovaries, or peritoneum, once infected, are very difficult to cure, frequently necessitating grave surgical operations.—*International Medical Magazine.*

### The Early Diagnosis and Practical Surgery of Cancer.

Herbert Snow, M. D., London, (*Am. Jour. Med. Sciences.* Great stress is laid upon the importance of early diagnosis. Early diagnosis, while difficult, can be greatly aided by remembering that "malignant lesions are especially prone to attack degenerating organs and degenerating people. With the exception of a numerically small congenital group of tumors which I have elsewhere classified under a special term, *blastoma*, and which mostly differ from ordinary cancer in rising spontaneously, malignant new growths are almost entirely confined to women above the age of 34, to men past 40. Further they appear in organs which have fulfilled their purpose and are undergoing devolution, or else intestines whose vitality has become conspicuously impaired."

Every tumor first noticed in the breast at or after the thirty-eighth year epoch is, in the great majority of cases, principally malignant; in the remainder it is certain sooner or later to become associated with malignant features in one form or another. From this sweeping rule, the most sweeping cyst within the gland parenchyma, a dilated acinus or dilated duct is not exempt.

Again it is laid down as an axiom that no average species of malignant tumor in the adult ever appears without an adequate and generally ascertainable cause.

About 11.7 per cent. of cases of cancer of the breast follow sudden injury—a blow or fall; the remainder are consequent upon some agency of a neurotic character impeding the normal devolution of the mamma.

Dr. Snow lays great weight upon "mental distress." He states that he has "known of one or two cases" follow an attack of influenza.

These statements cannot be accepted as in any way proven, although they should be given careful consideration as coming from a

man whose opportunities for observation in this disease have been exceptionally great. The mere fact that a cancer was first noticed shortly after an attack of influenza gives no scientific proof that such attack was an exciting cause rather than a coincidence. The fact that influenza is a disease so widely prevalent still further weakens the argument.

The physical signs of cancer are very well described.

In doubtful cases he believes that too much reliance should not be put upon the microscope, and cities the case of the late Emperor Frederick as a striking example.

Being of the cancer age and "suffering from steadily progressive laryngeal symptoms, the *a priori* probabilities in favor of epithelial cancer were very considerable. Yet in fallacious reliance upon certain microscopic indications of no more than merely negative value, the only measure which afforded a prospect of cure was rejected with quickly fatal result."

"The same historical event further demonstrates what is familiar to the practitioner in cancer, that the microscope for diagnostic purposes is of doubtful use."

Its conclusions may be taken without hesitation for positive purposes, but rarely or never for the negative. They may show that cancer is present, but cannot be trusted to prove its absence.

Treatment is briefly dealt with. Each case should be treated on its own merits. Early and very thorough removal when possible, but severe and protracted operations upon persons already in an exhausted condition from long standing malignant disease are greatly to be deprecated.

Under existing conditions of practice, wherein cancer is seldom brought to the notice of the surgeon in its incipient stages, comparatively few operations should take place, but these should be searching and thorough.

The writer strongly advocates opium, and believes that opium persistently given from the earliest moment at which there is reason to believe the disease incurable by surgical means, not only materially prolongs the individual's life, but also has often a more marked effect in arresting the growth.

Iron, arsenic, quinine tonics in general are useless except as *placebos*."

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### Aseptic Surgery for the County Practitioner.

Dr. James B. Bullitt makes the following observations:

1. Coats and cuffs should be removed, a clean apron or towel fastened over the front; hands and arms are scrubbed in hot soap and water; special care is to be given to the nails; the hands are then rinsed in boiled water or alcohol.

2. The field of operation is rendered aseptic by being thoroughly washed with soap and warm water, any hair being shaved. This is followed by alcohol or ether.

3. Sheets, towels, aprons, etc., can be completely sterilized by being scrubbed and then boiled in a five per-cent. solution of washing soda.

4. Ordinary cheese or butter-cloth makes an excellent gauze, and can be sterilized by being placed in a steam sterilizer for an hour. It is then put in a jar that had been boiled and tightly stoppered. Iodoform can be sprinkled over it when needed.

5. The best sponges are cotton-wool tied in butter-cloth and placed for an hour in the steam sterilizer. Sterilized heavy linen make good substitutes for large flat sponges in abdominal operations.

6. Silk for sutures is sterilized by being boiled for fifteen minutes in the soda solution. It is then dried in the sterilizer and placed in sterilized, stoppered bottles, containing a five-per-cent. carbolic acid solution.

7. For flushing out a cavity, nothing is better than boiled water, or a physiological saline solution that has been boiled.—*American Practitioner and News.*

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### The Surgical Treatment of Pulmonary Cavities.

From a study of the present aspect of the surgery of the lungs, Dandridge (*Annals of Surgery*) conclues that a certain number of pulmonary cavities can be successfully dealt with by incision and drainage. Tuberculous cavities in the lower portion of the lungs, if single and superficial, and if the general condition of the patient permits, should always be opened. Cavities at the apex should only be opened when there is free and persistent fetid expectoration that has resisted treatment, and the remainder of the lung is not involved. Abscess, gangrene, and hydatid cyst should be opened and drained whenever they can be located. Closure of the pleura should be insured before the evacuation of a cavity is attempted. In case of pyo-pneumothorax the fistulous track should be explored, and any cavity freely laid open by means of the cautery. Cavities that have been opened are best treated by packing with gauze, preferably impregnated with iodoform. The further careful trial of such agents as iodoform, chlorin-gas, and zinc chlorid is desirable to determine whether or not the tuberculous infiltration may be modified by them. It is also desirable, for the further extension of surgical interference in pulmonary cavities, that the means of locating such cavities and of determining their size and the exact character of the tissue that overlies them should be perfected by further study, and for the accomplishment of this the surgeon must look to the physician.

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### The Early Treatment of Carcinoma Uteri.

Kelly contributes a valuable summary of this subject to the *New York Medical Journal.*

The large number of cancer cases constantly applying to Kelly for relief have induced him for the past three years to adopt certain

stringent rules with regard to his own patients, which he has taught for the same period in his lectures at the Johns Hopkins Hospital.

The end in view is two-fold. First, by treating cervices liable to become cancerous, and thus prevent the formation of this neoplasam; and secondly to detect cancer of the cervix at a sufficiently early date to successfully eradicate the disease.

1. It is the duty of the obstetrician to see each patient at his office from two to three months after her confinement, and there to examine and make a careful record of the condition of the pelvic structures, stating accurately what lesions have been produced by the confinement.

2. Cervical lacerations should be carefully described, noting the position and depth of the tear and the appearance of the lips. Lacerations require no treatment when the lips are thin, uninfiltrated, and lie together. Thick, infiltrated, and everted lips associated with cervical catarrh call for depletory treatment, followed by repair of the laceration.

3. Every woman who has passed thirty-five years of age and has borne a child should have this examination made without delay by a compitent physician, and if the cervical lips do not appear perfectly sound she should be kept under observation and examined at intervals at from six to eight months.

4. Every woman over thirty-five, with a cervical tear, should be examined at least once a year for ten years, or longer, if the appearance of the lacerated area is not perfectly healthy.

5. These rules apply with special force to patients whose family history shows a marked inclination to cancerous diseases.

If these rules are conscientiously observed there is not a shadow of doubt but that thousands of lives would be saved yearly in this country alone by timely interference with a disease so markedly local and accessible in its origin.

The author states that he feels that while we are searching for a cure for cancer, the line of progress in the immediate future for the gynæcologist is clearly in the direction of prophylaxis and anticipation, either preventing or discovering the malady in its earliest stages.

## ARMY AND NAVY.

### CHANGES IN THE U. S. ARMY FROM APRIL 15, 1894, to APRIL 21, 1894.

Captain Nathan S. Jarvis, Assistant Surgeon, will be relieved from duty at David's Island, New York, upon the arrival of Captain Samuel G. Robinson, Assistant Surgeon, and will report in person to the Commanding Officer, Willett's Point, New York, for duty, relieving Captain William P. Kendall, Assistant Surgeon. Captain Kendall, upon being so relieved, will report in person for duty at Fort Columbus, New York.

PROMOTION.

Captain James C. Merrill, Assistant Surgeon, to be Surgeon with the rank of Major, March 13, 1894, vice Bartholf, retired from active service.

First Lieutenant Allen M. Smith, Assistant Surgeon, will be relieved from duty at Fort Custer, Montana, at the expiration of his present leave of absence, and will report in person to the Commanding Officer, Fort Reno, Oklahoma Territory, for duty at that post. First Lieutenant James M. Kennedy, Assistant Surgeon, is relieved from duty at Fort Riley, Kansas, and ordered to Fort Custer, Montana, for duty.

By direction of the President, Captain Alonza R. Chapin, Assistant Surgeon, will report in person to the President of the Army Retiring Board at Fort Bliss, Texas, for examination by the Board.

The leave of absence granted Captain Ogden Rafferty, Assistant Surgeon, is extended eighteen days.

First Lieutenant Charles Willcox, Assistant Surgeon, is relieved from temporary duty at Angel Island, California, and will rejoin his proper station, the Presidio of San Francisco, California.

### U. S. MARINE HOSPITAL SERVICE FOR THE FIVE WEEKS ENDING APRIL 21, 1894.

Murray, R. D., Surgeon, to inspect Quarantine Stations of Florida, April 17, 1894.

Bailhache, P. H., Surgeon, to proceed to New London, Conn., as Inspector, April, 18, 1894.

Mead, F. W., Surgeon, to report to Chairman Committee on District of Columbia, U. S. Senate, for special duty, April 7, 1894.

Carmichael, D. A., P. A. Surgeon, to report to Medical Officer in Command at San Francisco, Cal., for temporary duty, April 11, 1894, to proceed to Port Townsend, Washington, and inspect M. H. S., and Quarantine Service, April 21, 1894.

Brooks, S. D., P. A. Surgeon, to proceed to Chicago, Ill.,, for temporary duty, April 3, 1894.

Bratton, W. D., P. A. Surgeon, to report at Bureau, April 16, 1894, to proceed to Riedy Island, Quarantine, and await orders, April 20, 1894.

Vaughan, G. T., P. A. Surgeon, detailed as Chairman Board for Physical Examination of Candidates, Rev. Marine Service, March 19, 1894.

Cobb, J. O., P. A. Surgeon, to proceed to Seattle and Tacoma, Washington, as Inspector, April 12, 1894.

Wertenbaker, C. P., P. A. Surgeon, granted leave of absence for two months, April 3, 1894.

Brown, B. W., Assistant Surgeon, granted leave of absence for six days, April 7, 1894.

Decken, C. E., Assistant Surgeon, placed on "Waiting Orders," April 1, 1894.

Strayer, Edgar, Assistant Surgeon, to proceed to Vineyard Haven, Mass., for temporary duty, April 4, 1894.

Oakley, J. H., Assistant Surgeon, to proceed, to San Francisco, Quarantine Station for temporary duty, April 11, 1894.

Prochazkae, Emil, Assistant Surgeon, to proceed to Cleveland, Ohio, for temporary duty, April 2, 1894.

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## ORIGINAL ARTICLES.

### ENDOMETRITIS: ITS PATHOLOGY, SYMPTOMATOLOGY AND TREATMENT.*

WILLIAM W. STEWART, Columbus, Ga.

In beginning the discussion of this subject, I do so feeling that upon these lines of reasoning hang the only true conception of endometritis and its treatment; these conclusions are drawn from a large clinical experience and a close study of its pathological conditions. I will classify the conditions as simply as possible, take up its etiology and pathology and discuss its treatment from the standpoint of its pathology.

We have simple, septic and gonorrhœal. Under the head of simple are gathered all those conditions inflammatory in character, invading the endometrium produced by the following causes:

Displacements causing chronic congestion and hypertrophy.

Imprudent exposure during menstruation.

Retention of menstrual flow or mucus by cervical obstruction.

Sexual abuse, either in intercourse or masturbation.

Fevers, eruptive and protracted simple.

Frequent miscarriages.

Traumatism by intra-uterine instrumentation or pessaries.

Under the head of septic are gathered all those causes by which septic material or germs are implanted upon or within the mucosa, as by dirty instruments or hand.

Decomposing menstrual blood or lochia infected by lack of cleanliness at menstruation or abortion. (Those forms arising at confinement come rather under the head of puerperal fever).

Torn perineum, which makes of a normally closed vagina a cavity frequently filled with air, thus opening broad avenues for infection.

Gonorrhœal alone caused by introduction of the gonococci.

We may find the pathology of simple metritis one of two forms:

Primarily, and by far the most common, is a hypertrophied condition of the mucous membrane follicles, tortuous but retaining in its integrity its epithelial covering which presents a swollen appearance; muscular walls thickened, often causing decided enlargement of uterine body; blood vessels engorged and turgid, aiding in the local œdema; small capillaries multiplied in number and distended with blood, bleeding freely on slight traumatism or over-exertion; crypts between follicles filled with glairy mucus and lymphoid cells which are constantly discharged as a leucorrhœal discharge.

From the super-nutrition produced by the over-supply of blood, there often springs into existence fungosities, which are truly hyperplastic cells; or following a confinement or abortion, small particles of decidua or placenta may remain, which take on new life and growth forming fungoid masses. In either condition, there is constantly thrown off a mucoid discharge, varying in color by the number of lymphoid and desquamated epithelial cells which it contains. Either of these growths at the menstrual period may produce metrorrhagia and often alarming hemorrhage.

Secondly: The atrophic form in which the uterine walls are hardened by sclerosis,

*Read before the Georgia State Medical Association, April, 1894.

the mucous membrane almost devoid of epithelium and closely adherent to submucosa, crypts few in number. This condition is always a secondary one, and is invariably associated with amenorrhœa and dysmenorrhœa of a distressing and intractable form.

The symptoms and many complications arising from endometritis are of much interest, illustrating more perfectly the effect of the sympathetic nervous system on the different organs of the body and the general health than any other disease. The leading symptoms of endometritis are headache, occipital and parietal in location; flatulence; indigestion, fermentative in character, produced by dilation of the stomach, which is almost constantly associated with endometritis of long standing; pain in either breast, usually the left; great fatigue from exercise; leucorrhœa distressing in character, in the acute forms quite profuse and sometimes of very bad odor. In the atrophic form the leucorrhœa is absent or very slight, but all other symptoms are usually present in aggravated form. In both forms, the nervous system is thoroughly shattered, often producing hysterical phenomena whose form is legion. Sufferers from this trouble quickly develop a decided cachexia, often suggestive of malignant trouble, though none exists.

The treatment of the simple acute endometritis is almost sure to yield prompt and good results when the condition does not exist in an aggravated form, and can be taken early. The greatest benefit and flattering results can be obtained by change of air, well-regulated hygiene, exercise and nutritious diet, combined with a judicious administration of chalybeates and arsenic. At the menstrual period, rest in bed throughout its course, to be continued for at least four successive months. Metrorrhagia and dysmenorrhœa, if they exist, are well controlled by the judicious use of fluid extract of viburnum prunifolium, hydrastis and cannabis indica.

It is, however, the misfortune of both physician and patient, that when the metritis first makes its appearance, it is looked upon as a matter of small moment, the result only of a bad cold or over-exertion; or if the family physician is called, he is too prone to pass it by unheeded, with the remark: "If it trouble you, let me know." By slow degrees, the once simple condition passes into one which demands attention. And let me urge that that attention be prompt and decisive; for only by such measures will perfect results accrue. There are three lines of treatment to be selected from under these conditions, depending upon the variety and extent to which the process has advanced. In the simple acute, just passing into the more aggravated forms, and in the atrophic variety, simple gauze packing will in many instances prove all that is required.

To insure good results in performing this operation and to steer clear of the rock of sepsis, upon which so many surgical crafts are wrecked, it must be borne in mind that the vagina contains at all times thousands of pyogenic cocci, and it would be easy through this medium to infect a previously uninfected endometrium, thereby exchanging the simple for the septic form with its legion of complications.

To avoid such dire results, the strictest laws of antisepsis should be observed. A vaginal douche of one of two thousand sublimate solution should be given; then the external genitals should be thoroughly scrubbed with tincture of green soap and warm water, a perfectly clean speculum then introduced and vagina and cervix well wiped off with pledgets of absorbent cotton, dipped in a sublimate solution of one to two thousand; cervix should then be caught with a tenaculum and drawn forward, thereby straightening cervical canal; cervical canal should then be wiped out with absorbent cotton on an applicator having previously been immersed in same solution. If necessary, cervical canal should then be slightly dilated, cervix being steadied by tenaculum, a long strip of iodoform gauze three-quarters to one inch in width and fifteen to twenty per cent. in strength is looped over the end of a smooth uterine sound, and gently introduced to fundus; the sound is then withdrawn and point again entangled in gauze at the mouth of cervical canal, and gently introduced, thus loosely packing the uterine cavity with gauze. It is then clipped off about one inch from cervix, and a wider strip is introduced in the vagina over and around cervix. Covering this with a pledget of sterilized or borated cotton and operation is then complete.

This dressing is allowed to remain unmolested four or five days, patient prefer-

ably remaining in bed. This, however, is not absolutely essential to a successful result, as she may be permitted to remain upon a sofa or recline in an easy chair.

On the fourth or fifth day this dressing is removed, with the same precaution, and again packed. This procedure is repeated, if necessary, four or five times. If menstrual flow should appear, remove dressing and repack fourth day after its disappearance.

This treatment insures drainage and an aseptic healing dressing to an inflamed and œdematous mucous membrane in the more acute forms, and to a mucous membrane below the normal in its nutrition in the atrophic. In both instances, a perfectly scientific procedure which recommends itself from every standpoint of common sense and good surgery.

In the acute forms, this treatment by drainage and antiseptic dressing, quickly brings about resolution and restores the engorged uterus to its normal condition. In the atrophic it stimulates and insures better nourishment to an impaired and partially destroyed mucous membrane, and thereby often, to some extent, removing the troublesome dysmenorrhœa and amenorrhœa.

In the severe forms of the septic which have become chronic in character, with troublesome symptoms, curettage should precede the gauze packing, as already described.

The septic form in its acute invasion, presents a picture once seen, never to be forgotten, and as differentiation between gonorrhœal and septic can only be made by the microscope, this clinical picture will represent both.

A patient after miscarriage, abortion, dirty instrumentation, the wearing of a stem pessary or the introduction of the gonococci, is first taken with headache and languor, followed by chills and fever, usually high, micturition is usually frequent, urine small in quantity, bowels constipated, tympanites more or less constant, depending upon extent of invasion of pelvic peritoneum, pelvic region tender on pressure, and colicky uterine pains gradually becoming a dead ache. Examination reveals vagina hot and bathed in muco-pus, more or less hemorrhagic, uterus engorged and exquisitely tender to touch, exudative masses may be found surrounding uterus if adnexa be involved.

By speculum examination a large, turgid, often bluish cervix is exposed, from which there is constantly discharged a ropy muco-pus; cervix may be eroded, and in cases of late abortion and post-partum origin, patches of diphtheritic membrane may be found upon cervix and vaginal walls, due to the presence of the streptococci.

Endometritis, when produced by the gonococcus, is usually less rapid, and rarely causes death; whereas, in the septic form, death not infrequently draws a veil around the victim.

Whenever these conditions present themselves, never hesitate; act with prompt, thorough, clean and determined intent; with such, good results will surely come, and many lives of suffering and invalidism caused by diseased adnexa will be saved. Treat the disease as common-sense and good surgical rules surely dictate.

What surgeon is there to-day, who, having such a condition in any other portion of the body, would not make it his first step, his foundation for further treatment, to thoroughly cleanse the septic cavity, following it by good drainage?

Strike off the shackles of ignorant timidity which hold to vaginal douches, hot poultices, and lead to high mortality.

To thoroughly cleanse this cavity by referring to its pathology, it is found that staphylococci and streptococci are almost entirely found in the mucosa, rarely penetrating to the muscular wall; mucous membrane is bathed with pus, and in aggravated forms, the mucosa at times necrotic.

In the gonorrhœal the gonococci rarely pass deeper than the lymph spaces beneath the epithelial lining.

This being clear, the first step suggested is to remove the infected tissue which should be done thoroughly; a half procedure is worse than none. This should be procured by curettage, a description of the method of which is given later.

The presence of pelvic exudate is no contra-indication, but rather an indication for curettage.

Curettage, under all circumstances, should be performed with the greatest care. Bowels should be thoroughly evacuated the night prior to operation, with free doses of salts; one hour prior t o administration of anæsthetic an enema of warm water should be given; vaginal douche of one to two thousand sublimate solution should then be given, and external genitals should be well scrubbed with hot water and tincture of green soap, after

which the vulva should be covered with a pad of sublimate gauze held in position by napkin.

After anæsthesia is complete, instruments being sterilized, a speculum should be introduced, and any mucus that may have collected in vagina washed out with stream of sublimate solution one to three thousand; vaginal walls and cervix should then be washed with pledgets of absorbent cotton soaked in same solution, and cervical canal cleansed with cotton wrapped upon an applicator, immersed in either carbolic acid pure, or sublimate solution; cervix should then be caught by tenaculum, drawn down and steadied, dilator introduced and cervical canal well dilated; intrauterine washer should then be introduced, and uterine cavity washed with sublimate solution one to six thousand, after which dull curette is introduced to locate any decidual tufts, polypi or granulating masses; sharp curette should then be used with slow, regular strokes from fundus to external os, mucous membrane should be stripped off thoroughly, when sides have been completed, fundus should be treated in same manner, and successively curette should be rotated in each cornua, curette should continue till the sensation peculiar to the contact of the curette to muscular tissue is detected, and in all cases where uterus is not intensely softened, as in the puerperal state, there is a sound produced, harsh and grating in character, when the muscular wall is encroached upon by the curette; if as in the puerperal uterus, the muscular wall is very soft and danger of perforation is great, a rather flat, broad and moderately sharp curette should be used, and great care should be exerted to detect immediately the sensation produced by the muscular coat upon the curette.

Though the danger of perforation by sharp curette is so loudly sung, in careful hands, skilled in such work, such an accident should never occur. After curettage, uterus should again be washed out with sublimate solution, one to six thousand, till water returns clear; vagina should then be thoroughly cleansed, and uterus well packed, as already described. Vagina should be loosely filled with strips of gauze, and vulva pad of sublimate gauze applied, to be changed every six hours; water should be drawn at each dressing, and dressings allowed to remain unmolested as long as temperature remains down, till four days shall have elapsed, when it should be removed, as before. If temperature remain up, which is unlikely, dressings should be removed after twelve or twenty-four hours, as indicated by temperature, and uterine cavity again douched with sublimate solution one to six thousand, and uterus repacked as before. If temperature remain down, dressings can be left from five to six days, when they should be removed with antiseptic precaution, this treatment being continued till recovery is complete; the gauze insures perfect drainage, and with this plan of treatment laid down, temperature quickly falls, and pelvic exudations soon disappear.

In the septic and gonorrhœal forms, peritonitis may exist, and if so, bowels should be flushed daily by salts; should nausea exist, precluding the use of salts, enemata of

℞ Glycerine..... oz. 6
Oxgall (fresh)..... oz. 1
Rochelle Salts..... oz. 6
Aquæ q. s..... qts. 1
M. Use as one enema.

This should be given thirty inches up the bowels by high enema tube, and repeated as required.

By this treatment, rest and comfort, far greater than by morphine, will be produced, and "Nature's peritoneal drainage tube," as Lawson Tait has termed the intestinal canal, is constantly relieving the peritoneal cavity and general system of noxious material.

Beware of the delusion, often by temerity becoming a snare, of making applications of caustic agents to cervical canal as there exist authority for by many writers.

The best result that can be hoped for by such treatment is temporary amelioration of the condition. If the simpler forms are not made septic by the absorption of necrotic tissue produced by these agents, it goes on from a simple congestion thoroughly curable, to the atrophic form virtually incurable.

Caustics destroy the mucosa, and in its place scar tissue is substituted, through which the patient is compelled to menstruate. The sufferings of such an one may well be imagined.

In the cervical canal the severe caustics lead to cystic degeneration of cervix, produced by cicatricial contraction closing the ducts of the cervical glands.

On the other hand, after curettage and gauze packing, the mucosa is regenerated, fresh and healthy.

# HYDROPHOBIA.

HIRAM CORSON, M. D., PLYMOUTH MEETING, PA.

[CONTINUED FROM PAGE 631.]

## CASES.

As I have already stated, the committee appointed to report on this disease by the American Medical Association presented 106 cases which I have carefully read. In nearly all of them the predominance of the excited nervous system masked all other functional derangements and caused the seeming suffering. There was scarcely a single case that differed from those which we know were spurious, false ones as proved by their being utterly cured by means acting on the nervous system. When I spoke to you on this subject some months ago, and doubted whether there had been a single well authenticated case in our county, or even in the State, during the last half century, I was told of two undoubted ones here: one in Norristown and the other only a few miles away. I have since investigated them.

The first case was that of JOHN EARNEST. At the time he was bitten his hiredman, Miles Burns, was also bitten by the same dog. The following is the latter's account of it:

Mr. Sullivan, the hatter, had a beautiful, favorite hound which had been kindly treated; a pet too, in his family, being much in the house. One day the dog was absent, the next day he walked into Mr. Earnest's office, a mile below Norristown, and quietly laid himself down under the desk. He was such a kind, gentle animal, apparently without an owner, that Mr. Earnest concluded to take him along home—a mile away. So he coaxed him from under the desk and taking a rope in his hand attempted to put it around his neck. The dog was not used to being tied and when the stranger took hold of him, bit him on one of his fingers. Mr. Earnest then called on Burns and they succeeded in putting a rope around the neck of the frightened animal, but while doing it, Burns was also bitten. They then brought up the light wagon to take him away. As soon as he saw the wagon he sprang into it and lay down under the seat. He had been accustomed to be carried in that way by his master. Earnest took him home, but in pulling him into the barn to tie him there, the dog again bit him pretty badly on the wrist. When next day Earnest came to oversee his "works," Burns saw that he had his arm bandaged, and as he had only been bitten on the fingers when at the office, Burns inquired why his arm was bandaged, and was told of the second bite on the wrist. The first night after the dog had been tied, he jumped out of a high window and as the rope was too short to allow his feet to touch the ground he was choked to death. On the second day after he was bitten, Earnest did not come to the works, as was his daily habit, and Burns heard no more of him for two or three days, when he heard he was dead. It was of course reported as a case of hydrophobia. How can we account for this rapid development of the disease and the premature death? The period of incubation, as already stated, is weeks, not a few days, and the most rapidly fatal cases never, or rarely, die in less than four to six days. Mr. Burns stated to me that Mr. Earnest, from the moment he was bitten, became very uneasy, fearing the dog was a mad one, and worried about it all the time. He did not know that he went to any "mad-dog" doctor, but Dr. Duncan, who attended him, doubted its being a true case. It was evidently a death from fear. Mr. Burns' family, after the death of Earnest, insisted on his going to Mr. Emery, of Phœnixville, of whom I have already spoken. He never felt afraid of being infected and nothing came of it.

CASE II.—Mr. Burgess, machinist in Norristown, said: "His own dog seemed well and was about the shop, when, suddenly, he jumped up and ran into the street where he behaved in a most unusual way for awhile, after which he darted back into the shop, and through it into the yard where he dashed around wildly and finally jumped down into a cellar window. A fellow workman stooped down,

caught him by the back of the neck and jerked him out, and while tieing him was bitten. The wound bled freely. Mr. Burgess said to him, "This may be death to you, perhaps." He replied, "That is my business." Mr. B. of course thought the dog was rabid. As he had heard that dogs would eat castor oil, and thinking possibly that it might be pain which caused him to act so strangely, he put some oil in a saucer, and securing it to a handle about two feet long, held it to him. He at once dashed at it and lapped it up. In a few hours he was well purged and soon quite well and continued so. The bitten finger healed naturally, even without antiseptic dressings, and the bitten man suffered no further."

ANOTHER CASE.—His beautiful Spitz dog was much admired by a visitor, who put his hand on his head to pet him. The dog turned and bit him. A few days after this, the dog was sold, or given to another person whom he also bit, but they did not kill him, as is the common bad custom. The dog continued well as did the bitten persons. Now if they had killed the dog, what fearful anxiety they would have had, and if failing to go to a "mad-dog" doctor, they would doubtless soon have had false hydrophobia, believed by those who heard of it to be the real disease.

JOHN HOWARD, janitor of a church in Manayunk, was bitten on the wrist while standing at the church door, February 15, 1892. He did not take any notice of the wound for one and one-half hours. When the people were leaving the church, he then thought about it, and saw some blood on the wrist. Then he went to Dr. Custer, who dressed it—without naming hydrophobia—by applying nitrate of silver, then covered it with iodoform gauze. His pulse was then 90 to 96. Wound healed without further attention. October 28, almost eight months after the bite, he came again to Dr. Custer. He said he had slight chilliness, with spells of heat and aching and soreness in his body, but especially from the tips of the fingers of his right hand (the one bitten) up to the shoulder and back of the neck. There was no redness of the bitten part. He had not eaten that day before coming to Dr. Custer; seemed well; pulse 96. Next morning pulse was 110. The pains in hand, scapula and neck were worse; the pharynx was not red all over as in scarlet fever, but there were small, red, isolated patches, and also an eruption on the sides of the tongue, which Dr. Custer had seen described as a symptom of hydrophobia. On this Dr. Custer laid much stress, as pointing to rabies. The patient had no aversion to water, but when it had gotten somewhat down the throat, he would throw his arms above his head and make a motion with the jaws, as a person does when first stepping into a cold bath. Sometimes when the throat was filled he would jump up a foot or more as if to get air, his head being thrown back and elevated. Thursday he was thirsty, but when he drank acted as before, as if gasping for air. At midnight of 26th was worse. Dr. Custer was sent for—he was wildly raving and his wife was afraid of him. Dr. Custer then gave him $\frac{1}{4}$ grain sulph. morph., and before 8 o'clock in the morning, $2\frac{1}{2}$ grains with ʒj bromide of potassium. No effect in producing sleep or contracting pupils. Pulse 117. Passed no urine from the evening when he took the first half grain of morphia until the evening of the 27th, about 36 hours, when the catheter was used. Friday Dr. Todd was called, and he and Dr. Custer both thought it a case of hydrophobia. Dr. Custer felt sure that the patient himself so regarded it, although not a word had yet been said about it. They advised his removal to the hospital, but a vestryman counselled a visit to Dr. Fry. The policeman's account of the trip as given to me is, "that he and another officer took him in a wagon. He rode quietly, talked to them, did not seem to be any way wrong. They asked Dr. Fry if he could promise to cure him. He said (in the man's presence) 'if he had not had a spasm he could. They,' meaning the Fry's, 'had cured them, even after having had a spasm. He would give him the medicine.' He did so, got his ten dollars and they started for home." Now mark what happened. They had barely started when he got spasms again and had them all the way home. While they were away at Lansdale, I saw a notice of the case and next morning, at 8 o'clock, I took the train for Manayunk. I was too late to see him. The officers, after having been up with him all night till 4 o'clock, had started with him to Blockley Hospital, and had then returned. All the way to the Hospital he had the spasms, as they called them.

CLINICAL NOTES*. — John Howard; white; aged 42 years; native of England; married; church sexton.

Admitted to hospital about 6 A. M. October 28, from Police Patrol No. 18, from Manayunk.

A friend who came with patient said he had been bitten by a dog on the 15th of February, 1893. The wound was on the dorsum of the right hand. The wound was *not apparent* on admission. It was said that ever since the bite he had been much worried about it himself, and that his friends had constantly worried him by talking of the dangers of hydrophobia occurring. Also that advertising quacks (?) had sent him much literature on the subject which had kept his mind constantly on the dangers of hydrophobia. It was said that he had been drinking "some," but not to be often drunk for the last two weeks.

On October 24th, 1893, four days before his admission it was said he had began acting strangely, to "bark," to be more worried than ever, and be anxious to go to Lansdale and consult a quack (?). He grew rapidly worse within the next 24 hours, being entirely maniacal at times, and finally went to Lansdale on the 27th of the month, for treatment. On his return home he became very violent and had to be restrained.

On admission to hospital his temperature was 102.8°, pulse 144, without tension, respiration 30 but not particularly labored. The expression was drawn, anxious, all the movements of the face appearing to be done under great tension, by jerks as it were, and yet there were no convulsions; the eyes were staring intently at whatever attracted them, but were moving about constantly, pupils moderately dilated and not rapidly mobile. The patient was constantly expectorating small masses of tenacious spittle, doing it with effort and throwing it far from him. He said very little and what he said was incoherent and more in moans than in distinct words.

There was no appearance of spasm or convulsion; the skin of the neck showed no unusual sensibility; the patient drank freely several swallows and then stopped, apparently from simple restlessness, before he had emptied the cup, and spat out some of the water. He grew more restless as the day advanced, having various hallucinations. He said he was afraid of "sulphur" coming from the screen around his bed; he could both see and smell it and was afraid it would choke him. He would jump up in bed in great fright when the nurse would go near him with towel to clean his face from saliva, saying that she wanted to choke him. He sank into a condition of exhaustive coma about 1 P. M., lying quietly, breathing labored, limbs absolutely limp, temperature 101.6°, pulse 128, respiration 24. He remained in this condition, not responding to stimulants until 5:30 P. M. when he died, having been the house about 12 hours.

The death was reported to the coroner, who sent for the body and posted it at the morgue, and at the inquest the coroner's physician stated that "the membranes and cortex of the brain were deeply congested and death due to Acute Mania."

TREATMENT.— Hyoscine hydrobromate gr. $\frac{1}{100}$ with morph. sulph. gr. $\frac{1}{4}$ once hypodermically. As cyanosis came on and continued he had three hypodermic injections of strychnine, gr. $\frac{1}{30}$ with digitalis gtt. xv. Also whiskey and ether by hypodermic method.

* *Department of Charities and Correction. Bureau of Charities, Philadelphia Hospital, Philadelphia, Pa. Daniel F. Hughes, Chief Resident Physician.*

PHILADELPHIA, Nov. 8, 1893.

My Dear Doctor Corson.—I am glad to be able to comply with any request of Dr. Corson's. I have been a firm and practical advocate of your scientific treatment of Lung and Puerperal fever ever since graduating in 1878. I was fortunate enough to have as teachers Dr. Gross, Sr. and Dr. E. Wallace, and they early had their commonsense views impressed on my mind.

The patient, John Howard, was admitted and died during my absence in Chicago. He was diagnosed as acute delirious mania by Dr. Roland G. Curtin, who was called in my absence. I having, when home, charge of all acute mental cases from the moment of their admission.

I enclose you copy of our records of the case.

Again expressing gratification at being able to comply with a request of one who I hold in such high esteem as yourself, I am,

My dear Sir,

Very truly,

D. E. HUGHES.

### FALSE HYDROPHOBIA.

Testimony shows that, in the opinion of physicians who have well considered this subject, there is much reason to believe that false hydrophobia is a very common occurrence, while true hydrophobia in man is almost never met with.

I have already shown you that John Howard's case was evidently the result of long brooding over the fear of what might

result from the dog bite, and the added fear produced by the unintentional but positive confirmation of those fears by the friends and by the physicians. While the result of the case in the Hospital, as seen by the physician there during his last few hours, and the post-mortem examination proved that it was a false case, the result of fear—*mental terror*.

The Earnest case, so extensively noised abroad and so unanimously believed by those who never saw the case, from the testimony of Mr. Burns was without a shadow of doubt a false one. There was in that instance no premonitory stage. It was mental terror, so strong as to take from its victim all control of his nervous system. Poor fellow! There he was, his mind confronted with the fearful fate, in his belief the certain result of the dog bite. No sleep, no drink, no food aiding the mental terror to drag him to the grave. It is not strange that four days in such a condition should end his life. And yet we all know that it was not rabies.

And Burgess' case. How instructive! A dog evidently mad, as they believed, and yet cured by a dose of castor oil, and the man bitten by him when in this apparently rabid state never affected by it, though taking no preventives. So, too, his second case. The Spitz dog. Had he been killed every one would have believed him mad, and the person bitten through fear of consequences would, in the opinion of the people, have died mad.

The justy eminent Dr. Wm. A. Hammond, of New York, I have already told you gives many most interesting cases of false hydrophobia. And to the case given by Dr. Leedom, I may add a case in my own practice.

In 1856 I was called to a tall, gangling young man who was suffering, the messenger said, from "some kind of spells." Through a heavy rain I made my way to the house on the Schuylkill Hills. On inquiring below stairs about the case, I was told they were sitting around the store, when this youth, of about 18 years, wriggled himself out of his chair into the fireplace close at hand, and rustled about in some cold ashes left there. The mistress of the house was evidently fearing some great danger to the youth. On going up stairs I found him stretched out on a bed with four men, one to each arm and one to each leg, holding him at full length. He opened his eyes to the utmost and stared at me but not a word would he reply to any question asked him. After feeling his pulse and observing his behavior for a few minutes—he was turning his head from side to side as far as he could get it and snapping his jaws together as if he was biting at those on the sides of the bed who were holding strongly to his outstretched arms—I retired and going to the mistress, the mother of two young men who were holding him, asked her what she thought ailed him.

"Oh, doctor, I don't know," she said. "What do you think is the matter with him."

"There is nothing the matter with him," I replied.

As if offended she said, "I don't like to hear you talk that way."

"Well," I said, "please listen to me. I will go with you to his bed-side and then without looking at him at all, will say to you, as though I regarded him as not knowing anything talked about, 'This is a very serious case, but bad as it is I think I can cure him. I want you to go downstairs and heat an iron to a red heat, and in the meantime I will give him a powder that, if it act well, will begin to make him better in five minutes, and in twenty minutes will cure him entirely; but if it should not, then we will strip him naked and draw that hot iron down over his backbone to the very end of it.'"

At once, her son who was holding an arm, cried out, "Why, doctor, won't it burn him?"

"Burn him? Yes, it will burn him to the very bone, but what of that? It will heal again, and nobody will see the scar there."

As the woman started to go down, she turned and asked, "What kind of an iron shall I heat, doctor?"

"Any kind. A plough cutter will do—the nose of a plough cutter will be the very thing."

He knew well what a formidable thing a red-hot plough cutter would be. She left to heat the iron and I dissolved a quarter of a grain of sulphate of morphia in a tablespoonful of water. When ready I said to him in a very imperative tone, "Open your mouth." Slowly he opened it and I poured it in. Then, sitting close to the bedside I took out my watch, and when five minutes had passed, I said, "He

has had it five minutes, and if it acts well he should feel a little better." And then looking him steadily in the face, said, "Are you any better?" He responded by a grunt in which I could not discern yes, but which showed plainly that he was understanding well what I asked. Still holding my watch so that he could see it, when the ten minutes had come I said, "Are you any better?" There was a very indistinct yes. The fifteen arrived and the response was a fair, audible, "Yes." I at once opened the door and called the mistress. "He is better; the medicine acts well, but keep the iron hot." Then turning to the son I said: "He will be well when the twenty minutes are here, I need stay no longer. It is almost dark, raining hard, and I must start for home at once. But William if it should not cure him perfectly, don't forget the hot iron. Draw it down his back from his neck to his tail." Away I went. I went so quickly, that he might not be restrained by my presence, and that my orders so imperatively given would convince him that he could not escape them.

The next day at ten o'clock I rang the bell, and the mistress opened the door. The moment she saw me she threw her hands above her head and said: "Well, doctor, this beats anything thing I ever did see. You had not been gone more than half an hour before he was down stairs dressed up and went to the barn to do his work."

I forgot to say that before giving him the medicine I said to the son, "Why do you hold him?"

"Why, doctor he would knock his brains, out if we were to let go of him.

"Well," I replied, "They are his own brains, let him knock them out. Let go of him."

They did so, and he began a furious attack on the head board with both fists, but he hurt his knuckles and exhausted himself, and it was after that I gave him the medicine.

But had he been bitten by a dog? They did not know, but they were all convinced that he had hydrophobia. They had had him but a short time and did not know what might have happened him previous to coming to them.

But we have other testimony. The recent deaths of Mrs. Hohman and Elmer Pickering, of Frankford, from alleged hydrophobia resulting from the bite of the same dog, and the opinion of Coroner Ashbridge that no such disease exists, has awakened interest and led some prominent physicians to express themselves on the subject. Dr. Chas. M. Dulles, who has for years made a special study of it said: "Hydrophobia is not a distinct or specific disease. It has no symptoms peculiar to itself. It is really but a combination of the symptoms of many other diseases; and in all the cases I have examined, I have never seen any symptoms which did not belong to other and specific diseases—those of the brain, nervous system or throat. Those who believe in hydrophobia now, are those who believed in witch-craft in the old colonial days. Fear is a very large element of it. It occurs often and flourishes in those places in which it is believed in. See how it is in Paris. People thoroughly believe in it there and have a dread of it, and the result is a large number of cases constantly. What is true of Paris is true of France. The Rhine separates the French from the Germans but a short distance. The Germans do not believe in hydrophobia. They have very few cases in consequence, I believe, of their belief.

"There was a recent case of alleged hydrophobia in this city, in which an eminent specialist on nervous diseases, two regular practitioners and myself were concerned. It was a typical case of hydrophobia; there were all the symptoms popularly supposed to indicate the disease. We performed an autopsy. The person died purely and simply from meningitis located at the base of the brain and the spinal column. Another case with a regular practitioner and myself. It was as regular hydrophobia as I believe anything can be. The patient died. I predicted that lesion of the brain would be found. The autopsy revealed just the conditions I had prophesied, but remained (to others—the public) one of hydrophobia. Another thing. It is very common for the bite of a dog to be cauterized with silver and hypodermic injections of morphine to be resorted to in the later stages. There is no case on record in which these treatments have been used and the patient recovered."

Dr. Charles Mills, the eminent specialist in nervous diseases, said: "I believe that eight cases out of every ten of alleged hydrophobia are not genuine, and I am

not convinced that it is a specific and distinct disease. I have seen several cases and have been concerned in several more, and have participated in three autopsies. Of five cases in which there was every symptom that is coupled with hydrophobia, four were undoubtedly due to other diseases, and possibly the fifth was also. Meningitis and epilepsy enter very largely into the composition of hydrophobia. Imagination also plays a large part. There is a specific nervous disease known as hydrophobia. I now have as a patient, a woman who has long suffered from it. She has most intense horror of dogs, and it is a fact that, although in very good health otherwise, this woman actually remained inside of her house for eleven months, not daring to go out. She could not be induced to do so. A short time ago her husband happened to tell her that a dog had brushed against him as he was walking along a street. The wife's fears developed to such an extent that it was possible to calm her only by destroying the suit that her husband wore when the dog brushed against him as he walked. It seems odd, don't it? But it is perfectly true. The sight of a dog from one of her windows, if his tongue is hanging out, or if there is froth at his mouth, is apt to give her convulsions. Recently she heard that a dog had a fit on Thirteenth street. She at once begged all her family to avoid the locality, as much as possible. Now, if that woman should be bitten by a dog what do you suppose the result would be? How long do you suppose she would live? She would be likely to die of convulsions in 48 hours. I agree perfectly with Dr. Dulles that Pasteur's discoveries and his treatment have done more harm than good."

Of the thousands, yes tens of thousands of persons who are loud in their belief and knowledge—as they call what they have heard about cases—not more than one in a hundred, if one in a thousand, has ever seen a case either of the true or of the spurious disease. So I feel like giving the belief of a coroner who has investigated many cases called hydrophobia, which proved fatal. In the case of Mrs. Hohman, of Frankford, already referred to, a post-mortem of whose body was refused by Coroner Ashbridge, he wrote as follows in defense of his act: "This I refused to do because, from my experience and standpoint, there is no such malady as hydrophobia." In human beings, I suppose he meant. "As it is classed to-day, and for the past year, I have made no post-mortem in such cases, because the results yield nothing, nor does it prove anything in the interest of science, or decide anything definite as to the cause of death. All that has ever been found in post-mortems in the past twelve years *is a congested state of the brain*, and this will be found in all cases of death from convulsions and the like. In the epileptic the symptoms are precisely like those of so-called hydrophobia: frothing at the mouth, rigid jaws and convulsions. I have observed the same things at post-mortems upon persons apparently in previous good health, who have died from nightmare, or horrors; the brain congested in a similar manner. To my mind it is the effect of the mind over the body, producing acute nervous strain and disorder; and as to the blood-poisoning theory, that will not stand investigation. The treatment of Pasteur has few believers. If one would see the symptoms of a person dying in an epileptic fit, and it was said he had been bitten by a dog, it would be at once pronounced the worst case of hydrophobia known."

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### Diarrhœa of Dentition.

In the (*Ciencias Medicas de Barcelona*) in the treatment of the diarrhœa of dentition, the following preparation is found of use:

℞

| | | |
|---|---|---|
| Subnitrate of Bismuth..... | 4 gms | (℥j). |
| Lime Water..... | 8 " | (℥ij). |
| Fennel Water..... | 100 " | (℥iijss). |
| Syr. Orange Peel..... | 20 " | (℥v). |

One teaspoonful every three hours.

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### Acute Bronchitis.

Dr. Bartholomew uses:

℞

| | |
|---|---|
| Tinct. Sanguinariæ..... | ℥i. |
| Tinct. Lobeliæ..... | ℥i. |
| Vini Ipecacuanhæ..... | ℥ii. |
| Syr. Tolutani..... | ℥iv. |

M. Sig. Teaspoonful every three hours.

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### Thompson's Chloroform Liniment.

℞

| | |
|---|---|
| Chloroform..... | 2 ounces. |
| Alcohol..... | 2 " |
| Ammonia Water..... | 2 " |
| Spirit Camphor..... | 2 " |
| Tincture of Aconite..... | 2 " |

Spirit nitrous ether, sufficient to make 16 ounces.

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### Acne.

Dr. Hilles (*Deutsch Med. Woch.*) uses:

℞

| | |
|---|---|
| Sulphur Iodidi ..... | gr. x. |
| Lanolini..... | ℥i. |

M. Sig. Apply twice daily after washing the parts with hot water.

# COMMUNICATIONS.

## OPERATION WOUNDS OF THE THORACIC DUCT IN THE NECK, WITH A RÉSUMÉ OF THE TWO PRIOR RECORDED CASES AND TWO ADDITIONAL CASES.*

W. W. KEEN,† M. D.

When we consider the frequency with which operations are done on the left side of the neck in the vicinity of the junction of the jugular and subclavian veins for the removal of enlarged glands, for tumors, for goitre, etc., and of stab and other wounds, it is surprising that there are not a number of instances of wounds of the thoracic duct. The danger of wounding it may be greatly increased by the fact that Dieterich (Henle's *Anatomy*, 1876, iii. 453) has found the arch of the duct as much as 5½ cm. (over two inches) above the top of the sternum and touching the thyroid gland. Yet so far as my investigations have gone, I have only been able to discover two cases of wound of the cervical portion of the duct reported in surgical literature. To these to-night I add two more, one of my own, and another, the notes of which have been kindly furnished me by Dr. A. M. Phelps, of New York.

Even in war, wounds of the duct in any part of its course are practically unknown. In neither the Italian war of 1859, the Crimean war, nor our own late civil war, is there a single instance recorded.

CASE I. (Cheever's case.)—Dr. Cheever reports in the *Boston Medical and Surgical Journal* for 1875, p. 422, the case of a tumor of the neck, during the removal of which "the subclavian vein and a large vessel near the internal jugular were both wounded. The distended veins mixed up with the friable glandular growth gave way repeatedly under the forceps and ligature. At this time occurred a new source of difficulty. A transparent, viscid, coagulable, and colorless fluid ran out from the tumor and from the lower corner of the wound in quantities as large as an ounce at a time, some six separate times. Together with the dark venous blood, this fluid constantly obscured and filled the bottom of the neck whenever pressure by the finger or sponges were taken off." The inner two-thirds of the clavicle were then removed. "The subclavian artery was sought and pushed aside and an aneurism-needle passed between it and the vein, first out toward the shoulder and a ligature tied; and second, close to the sterno-clavicular articulation, where the needle and ligatures surrounded the venous trunks at or upon their junction in the left vena innominata. The artery was not wounded nor tied. All bleeding now ceased, but the transparent fluid still oozed out moderately. The wound was lightly packed with sponges and ferric alum; no hemorrhage occurred, and the transparent fluid did not soak through the sponges." The patient died from shock and exhaustion, thirty-six hours after the operation. "No formal autopsy was made, but an examination of the wound showed the subclavian vein tied externally, and also at the junction of the internal jugular and subclavian. The remains of the tumor extended two inches below the clavicle, but were enucleated without piercing the pleura. This fragment of tumor had incorporated into itself several venous trunks or sinuses caught and entangled in the gradual agglomeration of glands. There was no opening into the pleura, no sac running down into the thorax or axilla, no cyst in any direction. The source of the transparent effusion could not be traced. There would seem to be but little doubt that this fluid was lymph from a large branch of the lymphatics in the tumor, or more probably from the thoracic duct where it arches over to join the left subclavian vein. In contact with, if not surrounded by, the glandular enlargement, its thin and transparent walls were readily wounded in trying to remove the lower part of the tumor. No other source for the clear fluid could be found, there being neither cyst, hydrocele of the neck, nor pleural effusion to account for it. The

*Read before Philadelphia Academy of Surgery, April 2, 1894.

†Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, etc., Philadelphia.

fluid under the microscope exhibited no cells save a few stray blood corpuscles. The patient having fasted for twelve hours before the operation, there would be little, if any, of the milky emulsion of chyle in the duct.

"The fluid poured out of this wound coagulated after contact with the air in a firm jelly, just as blood coagulates. This no doubt was due to its fibrin. Its large quantity pointed to a considerable duct as its source, although it must be borne in mind that the whole lymphatic system of the neck was probably vastly enlarged, and secreted great quantities of lymph. Very probably the waste of nutritive plasma by this leakage of lymph in the wound hastened the exhaustion of the patient, and, if due to a wound in the thoracic duct, would have precluded his recovery."

CASE II. (Boegehold's case, *Arch. f. klin. Chir.*, 1893, vol. xxix. p. 443.)—In March, 1880, Wilms extirpated a tumor as large as a fist from the left side of the neck of a stout man forty-five years of age. In the course of the operation Wilms gradually neared the junction of the subclavian and jugular veins. As he was carefully scraping the tissue with a sharp spoon, suddenly there poured out over the operation field a stream of whitish fluid the diameter of a straw, which mingled with the rather freely flowing blood. This fluid could not well be anything else than chyle, for a wounded lymph vessel would have given exit to a clear, or at the most a slightly yellowish, but not whitish, fluid. There was no abscess nor any purulent pleurisy. After this wound of the thoracic duct, the extirpation of the tumor was terminated at once. The milky fluid no longer escaped, and on account of the considerable hemorrhage the idea of securing it in the depth of the wound was abandoned. The wound was then packed with salicylic wool and an antiseptic bandage applied. The packing was removed the next day without any further appearance of the chyle. The patient recovered without incident, and six months afterward died, presumably from pulmonary metastasis of the carcinoma.

CASE III. (Case of Dr. A. M. Phelps, of New York; personal communication.)—June 4, 1893, at the Mary Fletcher Hospital, Burlington, Vt., Dr. Phelps operated on a malignant tumor of the left side of the neck. "It was found that the jugular vein passed through the tumor, and this necessited the removal of three inches of the jugular, near its junction with the subclavian. The tumor extended downward underneath the subclavian vein and involved the deep muscles of the neck. The wound was dressed four days later. There had been a constant profuse discharge, which at first was supposed to be serum, but its color, like that of skimmed milk, and its source from a single point in the wound, as well as its quantity, soon forbade that presumption. I estimate that about three pints a day had been lost. It was sufficient to saturate daily ten or fifteen ordinary bed-sheets folded in a number of thicknesses, in addition to saturating the surgical dressings. The man was rapidly losing flesh. A consultation of staff was held on June 11th, and the consensus of opinion was that the thoracic duct had been severed. The point of a probe the size of a large knitting-needle inserted at the point of evacuation entirely stopped the discharge. The point from which the liquid issued was caught by forceps, which were allowed to remain in place three days. The patient gained a pound a day after the discharge was stopped, and made an excellent recovery."

The duct cut, in his opinion, was one of the divisions or ramifications of the thoracic duct, but the staff thought that the main trunk had been severed.

The fourth case is my own.

CASE IV.—Miss S., aged twenty years, was first brought to me in November, 1892, by Dr. Melcher, of Mt. Holly, N. J. There was a small enlarged gland on the left side of her neck above the clavicle, a scar at a corresponding point on the right side, and another scar at the upper border of the right breast. From these two places showing scars, Dr. Melcher had removed glands which were undoubtedly tubercular. Just below the right clavicle and a little external to its centre was a tumor, evidently deep in the apex of the right axilla, firmly attached so as to be practically immovable, and extending, so far as could be ascertained, half way or more from the clavicle to the axillary border. It first appeared about a year ago. I judged it to be a series of enlarged glands, probably attached to the vessels. She had occasionally tingling and numbness in the right arm, and slight œdematous

swelling. Soon after she was here Dr. Melcher made an attempt to remove the tumor, but the hemorrhage was so great as to deter him, and he closed the wound, from which she made a good recovery.

Operation, Jefferson Hospital, January 28, 1893. I made an incision almost vertically in the axis of the body, from the clavicle about four inches downward. I came upon the tumor as soon as I was through the great pectoral muscle. Finding its extent, especially toward the axilla, greater than it appeared from the outside, I made two transverse incisions, converting the whole incision into a cross. I first dissected from the clavicle downward. I found the tumor adherent, not to the clavicle, but to the second rib and the costo-coracoid membrane. With a good deal of care and difficulty I was able to separate the upper border of the tumor from the clavicle and work my way downward and also outward toward the vessels. In a few moments I saw a part of the tissue collapse with inspiration, and I recognized that this was the subclavian vein.

I was finally able to remove the entire tumor, but only after one of the most difficult and tedious dissections I ever made. The tumor was a mass of enlarged glands extending three quarters of the way around the axillary vessels, the upper border alone being free. It was with the greatest difficulty that I could separate the tumor from the vein to which it was especially adherent, but I finally succeeded. The dissection took over an hour and the whole operation was nearly an hour and a half long. I button-holed the axillary skin at its posterior border and carried out a drainage-tube, otherwise closing the wound and dressing it as usual. The hemorrhage was moderate, not over eight or ten vessels requiring ligation.

February 11, 1893. Her recovery was rapid and gratifying. The highest temperature was 99.8°. The drainage-tube was removed in forty-eight hours, and the sutures on the third, fifth, and seventh days. On the eighth day she went home perfectly well.

Dr. Kyle reported as follows on the specimen: "Frozen sections from this specimen showed it to be tubercular. The sections were so arranged as to include portions of dense tissue, also the caseous mass. Macroscopically and on cutting through the specimen it resembled lymphosarcoma, which appearance could be produced by the enlargement of the gland, which would cause pressure on intervening tissue, giving it that peculiar fibrous appearance. By the methyl violet and blue stain the tubercular condition was easily recognized."

She returned to me December 12, 1893, with enlarged glands in the neck on both sides, just above the clavicles and in both axillæ, especially the right one. These glands were high up in the axilla on both sides and were apparently (especially on the right side) very adherent. In the neck the glands were rather peculiar, in that while they were very perceptible as tolerably large, nodular masses, evidently composed of a number of glands, the inner portion on both sides was soft, markedly lobular, and apparently contained some fluid. Those on the left side of the neck were larger and gave her a good deal of annoyance and pain, somewhat resembling in this respect those in the right axilla. I advised her therefore to have them removed.

Operation, Jefferson College Hospital, December 15, 1893. Present, Prof. Clayton Parkhill, of Denver, and Drs. Hearn and William J. Taylor. Drs. J. Chalmers Da Costa and Weaver assisted me. When the patient was etherized and recumbent, I saw a marked change in the condition of all the tumors. The one in the left axilla just below the clavicle could not be found. That on the right side was apparently very much diminished, as were both of those in the neck, the right one being partially perceptible and the left moderately so. The soft, fluid part of the cervical swellings had entirely disappeared.

The right axilla was opened by an incision passing along the border of the tendon of the great pectoral muscle. The operation was tedious and very difficult mechanically, by reason of the extensive and very dense adhesions from the periadenitis and from the former operations. The adhesion to the axillary vein was particularly solid and sometimes was almost as tough as though they had been made of leather. However, after very slow, careful, and patient dissection I was able to get out a large mass of glands.

Having finished the dissection of the glands in the right axilla, I next made an

incision above the left clavicle to remove the glands there. There was a great deal of periadenitis, creating very firm adhesions, especially downward and inward toward the junction of the left internal jugular and subclavian veins, both of which were laid bare nearly, but not to their junction. I was carefully dissecting these adhesions away with Allis's blunt dissector, when suddenly I made a small opening in what was apparently an adhesion, and instantly there welled out from it a perfectly limpid fluid. At first I thought I had opened a cyst; but, on observing that the fluid escaped continuously and with a very evident respiratory rhythm, and that the fluid apparently flowed from a tear one-fourth of an inch in length, from a tube about one-eighth of an inch in diameter, it occurred to me that it was either one of the dilated left lymphatic ducts just before their entrance into the thoracic duct, or that, more likely, it was the thoracic duct itself. About two ounces of fluid escaped in all. I sucked up a little of it with a hypodermatic syringe. It coagulated in a few minutes. Dr. Da Costa suggested that the distinction between the two fluids, *i. e.*, from the lymphatic and the thoracic ducts, could be made by the fact that the fluid in the thoracic duct should be milky, but as she had taken no food since the previous evening (eighteen hours) this gave no help. Against its being the thoracic duct was the fact that it was just behind the upper border of the clavicle and, therefore, lay too high for the thoracic duct; but as the glands were being dragged upward, this objection I felt was not valid. Also, although I could introduce a grooved director into the tube from which the fluid was escaping, the director only entered about one-half to three-quarters of an inch when it met some obstacle. In such a locality and in such a novel experience, I did not care to enlarge the boundaries of science at the possible expense of my patient, and hence I decided to desist from further exploration and remedy the apparent mischief at once. Accordingly I closed the opening by the pressure of one finger, and carefully removed the glands, which were almost entirely loosened at the moment of the accident. Then I seized the two edges of the opening with forceps, and by means of the finest Hagedorn semi-circular needle and fine silk I closed the wound. Some little leakage still took place. There was also a little of a similar fluid from the upper part of the wound, but it seemed a general oozing rather than from any distinct vessel. The remainder of the operation was completed with ease, although it was extraordinary what a large mass of glands I removed, in view of the almost utter inability to perceive them when she was etherized and recumbent. Nothing was found to account for the soft and apparently fluid part of the tumor noticed when she was first examined. This soft mass was at least one and one-half inches external to the site of the opening into the thoracic duct and nearly as much above it.

A drainage-tube was inserted into the wound, but was removed after five hours, having served its function of conducting off most of the bloody wound-fluids, and I feared that its retention would be followed by a lymphatic fistula. Any escape of lymphatic fluid from the thoracic duct I thought should be repressed as quickly as possible by absolute closure of the wound. During the five hours the amount of wound-fluids was very large for so small a wound, amounting to nearly a pint, and its light color showed that the small amount of blood was diluted with a great deal of clear fluid. The dressing the next day was partially saturated by probably an ounce or two, and after that was dry.

On the eighth day after the operation, having made an absolutely uneventful recovery, she went home. Not the slightest evidence of trouble appeared in the wound in the neck, neither swelling, redness, nor pain. Her weight on December 11th, four days before the operation, was 106 pounds and eight days after it, in about the same clothing, 103 pounds. Her highest temperature was 99.8°, on the evening of the operation. The following table shows her weight since the operation:

| | Weight. |
|---|---|
| December 28, 1893 | 100 pounds. |
| January 6, 1894 | 101 " |
| " 12, " | 100½ " |
| " 19, " | 100¾ " |
| " 26, " | 100¾ " |

March 15, 1894, same weight; her cough troubles her considerably.

Dr. Kyle reported that in the fluid there were many lymphocytes or lymph-corpuscles of different sizes; some few were slightly granular, and there were many fat or oil-globules, small in size, but large in number. The macroscopic appearance of the fluid was slightly opaque.

Remarks.—First. The anatomy of the thoracic duct. As has been shown here to-night in the beautiful dissections of Mr. Ward Brinton, the thoracic duct does not always empty by a single mouth at the junction of the left jugular and subclavian, but is apt sometimes to break up into two or three ducts or even into a delta, some of the branches emptying into each of these large veins, and, as Dr. Phelps finds from his dissections of the duct, into other deep veins of the neck. Verneuil (*Le Système Veineux,* 1853) states that Boullard in twenty-four cases found it to empty by one mouth eighteen times, by two mouths three times, by three mouths twice, and finally once by six mouths, of which two opened into the subclavian, two into the jugular, and one each into the external jugular and the vertebral veins. Lacauchie (Henle, *l. c.*) gives an instance of four terminal canals. In twenty-one injections of the duct Boegehold found that in two cases it divided at its anastomosis with the veins into three or four branches, and in one case, about two inches before its termination, a branch as large as a straw passed to the subclavian, the main trunk emptying at the angle between the subclavian and the jugular. It is, therefore, possible in all these cases of wound that not the main trunk, but one of these branches—perhaps, as in Boegehold's case, a branch as large as a straw—was injured. Bayford (Boegehold, p. 447) records one case of dislocation of the thoracic duct from a curvature of the spine, which might increase materially the possibility of its being wounded should an operation have to be done in such a case. Boegehold (p. 455) also quotes a case from Scherb of the partial obstruction of the duct by a calculus. The occasional great height of the final curve of the duct in the neck has already been mentioned.

Secondly. The character of the fluid. There could be no possibility that the source of the fluid was other than the thoracic duct in Boegehold's and Phelps's cases, as, from its milky color, the fluid was evidently chyle. In the other two cases the fluid has been so clear that it resembled serum. I do not know the relation of the hour of operation to the hour of the last meal in Cheever's case. In my own case the patient, having had two prior operations, and suffering from ether nausea, had refused to eat any breakfast whatever, and when I operated, at twelve o'clock noon, it was eighteen hours since she had eaten the previous meal. The quantity of the fluid in Phelps's case was very extraordinary, and leaves no doubt that it could only have been from the thoracic duct. In Cheever's case and my own the quantity and character of the fluid make it reasonably certain that it was from the duct, but it is not so demonstrably sure as in the other two cases.

Third. Treatment. Cheever's case was so speedily fatal from other reasons that no inferences can be drawn from it. In Boegehold's case packing was sufficient to arrest the flow and the patient recovered. In Phelps's case pressure-forceps arrested it entirely. In my own case the suture of the vessel was perfectly feasible, and the result was most satisfactory. It seems to me clear that if this procedure can be adopted it should always be done. I very anxiously watched the weight of my patient from week to week for the first few weeks after the operation. Then, finding that she was not losing ground, it was clear to me that she had permanently recovered from the accident, which at first caused me much anxiety.

Fourth. Experimental researches. Boegehold, so far as I know, is the only one who has tested the question by experiment. In his first two experiments, in dogs, he exposed the thoracic duct at its entrance into the veins and wounded it with scissors. Pneumothorax followed, but disappeared within five days. Eight days after the accident the dogs were killed. No trace of pleurisy was found, and the duct at the level of the fourth dorsal vertebra was surrounded with a thin whitish-red clot of fibrin. The duct was divided for over one-fourth of its circumference. In the next three experiments the duct was cut obliquely. On the following day the dogs were evidently sick, with a rapidly increasing frequency of respiration. On the evening of the third or fourth day they died, and at the autopsy the pleural cavity was found full of chyle. The cause of death was compression of the heart and lung from effusion of chyle. In the sixth and seventh experiments he placed a canula in the duct. This was followed by suppurative pleurisy, with death respectively on the fourteenth and tenth days. At the autopsy the pleura was found covered with fibrinous clots, but as the fever had sub-

sided on the fifth day, he ascribed death to the loss of chyle. In the eighth experiment he ligated the ends of the duct in the neck. On the fourth day he inserted his finger into the pleural cavity. The duct was easily found as it was distended with chyle. He wounded it slightly with scissors, and seventy-two hours later the dog was killed. The duct and the receptacular were distended with chyle, and at the site of the wound a small red fibrinous clot was found. Very little chyle had escaped on account of the smallness of the wound.

As a result of his experience he thinks that the complete integrity of the duct for the support of life is not absolutely necessary. He gives a number of instances of complete obliteration or compression of the duct without any symptoms. The collateral circulation of the lymph seemed to be established, and Schmidt and Mulheim have shown experimentally that the closure of the duct in dogs, in whom the canal is always single, did not affect either the digestion or the absorption of albuminous matter. An injury followed by closure of the duct, therefore, is not necessarily fatal. The danger is that if the duct is not closed, either compression of the lungs and heart from the constantly augmenting accumulation of chyle in the pleural cavity will prove fatal, or that the loss of nourishment will be lehtal if it escapes externally. Wounds of the duct seem to be entirely capable of healing. Should the heart and lungs be compressed, clearly the pleural cavity should be opened in order to avoid the immediate danger of death from compression, as is shown by Kirchner's case (*Arch. f. klin. Chir.*, 1885, p. 156). This seems to have been an undoubted and severe rupture of the thoracic duct within the thorax, and yet was followed by recovery. It shows that even rupture of the duct may not necessarily be fatal.

A little girl, nine years of age, healthy although not very strong, was pushed violenty against a window-sill, injuring her at the level of the third rib. Marked orthopnœa, with cyanosis and sweating, and dilatation of the nostrils followed in the course of two weeks. The right half of the thorax was broader than the left up to the level of the spine of the scapula and the third rib. The heart pushed to the left, and the liver extended two fingers' breadth below the border of the ribs. The temperature was normal. The right chest was punctured in the fifth intercostal space and a litre of fluid resembling milk was poured out. Examination by the microscope showed undoubtedly that it was chyle. Ten days later the dyspnœa was so great that puncture was again contemplatad, but under warm baths and slight purgation by senna the improvement was such that puncture was not done a second time, and complete recovery followed. In six months the child was better than prior to the attack.

Kirchner states that, even including some uncertain cases, there are but seventeen on record of injury of the thoracic duct, either in the neck, chest, or abdomen; six resulting in chylous ascites; nine in chylo-thorax; one of hydrops lacteus from the collection of lymph in the mediastinum; and finally, the case of Boegehold, the only instance he gives of injury in the neck. The three additional cases I have reported here bring the total number up to twenty, and of wounds in the neck alone to four.

Busey (*Trans. Assoc. Amer. Phys.*, 1889, vol. iv. p. 76) refers to a number of cases of injury to peripheral lymphatics by bleeding, etc., and also the effusion of chyle into the thorax, abdomen, tunica veginalis testis, etc. In the discussion Welch said: "I do not think that the mere occlusion of the thoracic duct, still less obstruction to the venous flow in the subclavian veins, is followed by serious interference with the flow of lymph and chyle. I have found the thoracic duct completely occluded by a tuberculous thrombus in a case of acute miliary tuberculosis without any such effect."

The pressure in the thoracic duct is not very high. According to Weiss, in the neck it reaches from 9 to 15 mm. of mercury.

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WITH A GRAIN OF SALT.—Mrs. Hicks. "I saw it stated in a paper that mosquitoes have twenty-two teeth."

Hicks.—"Then they probably have eleven."

Mrs. Hicks.—"Why eleven?"

Hicks.—"It isn't safe to believe over half you see in the papers."—*Truth.*

---

A RUSSIAN scientist has succeeded in tracing all man's disease to the fact that he wears clothes.

# TRANSLATIONS.

## A RARE CASE OF SPONTANEOUS GANGRENE.†

Dr. Zeller reports the case of a chlorotic patient, aged 20, who had experienced pain and weakness in the joints of the right arm for the past year; this was followed by tingling sensations in the hand and bluish discolorations of the finger tips. These manifestations were at times accompanied by a complete loss of sensation. One of these attacks was followed by necrosis of the fingers of the right hand, extending to their middle joints, and necessitated amputation. The arteries did not spurt when cut. Angiospastic gangrene was diagnosed, there being an absence of any other etiological factors.—*Berliner Klin. Wochen.*, 1893, No. 52.

—W.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### CHRONIC CONSTIPATION.

The (*Gazzetta Medica di Roma*, No. 5, 1894) advises the following preparation in chronic constipation:

℞

| | | | |
|---|---|---|---|
| Aloes | o | 25 | (grs. iv). |
| Sulphate Strychnine | o | 015 | (gr. ¼). |
| Extr. Belladonna | o | 09 | (gr. j ½). |
| Powdered Ipecac | o | 35 | (grs. vss). |

Sufficient for twelve pills. One every evening.

### IRRITABLE BLADDER.

Dr. W. Chun (*Le Progrès Médical*, No. 11, 1894) speaks highly of the following formula in irritable bladder-polakiuria:

℞

| | | | |
|---|---|---|---|
| Benzoic Acid | 4 | o | (3j). |
| Borax | 6 | o | (3jss). |
| Water | 180 | o | (3vss). |

A soupspoonful three times a day.

This mixture will rapidly quiet the desire to urinate so frequently especially when it is due to an excess of phosphates in the urine.

### A LOCAL APPLICATION FOR UTERINE CANCER.

Dr. Lucas (*Le Progrès Médical*, No. 11, 1894) advises after the diseased surface has been carefully cleaned, local application of the following powder:

℞

Powdered Benzoin.
Powdered Iodoform.
Carbonate Magnesia.....āā 1.0-2.0 (grs. xv-xxx).

It diminishes the fetid discharge and prevents ulcerations around the vulva and perineum.

### ABSCESSES AND ULCERS OF THE CORNEA.

Prof. de Wecker (*Rivista Clinica E Terapeutica*, No. 2, 1894) claims that the modern rational treatment of ulcers and ulcerating abscesses of the cornea should consist of curetting the ulcer with a small and sharp curette with antiseptic irrigation. There is no destruction of healthy tissues as with the cautery. The remaining corneal lesion will rapidly heal without reinfection under an occlusive antiseptic bandage. After curetting it is necessary to irrigate the cornea with an antiseptic solution for some time in order to insure perfect asepsis. He proceeds as follows: With a small sharp curette the ulcer or abscess is scraped until all the white portions are detached, then profuse and prolonged irrigation with a 4 per cent. boric acid solution, and finally, an occlusive bandage.

### INJECTIONS OF ARTIFICIAL SERUM IN NEURASTHENIA.

Dr. Cheron (*Revista Medica de Bogotá*, February 15, 1894) claims to have obtained beneficial results in the treatment of neurasthenia with hypodermic injections of an artificial urine prepared after the following formula:

℞

| | | | |
|---|---|---|---|
| Chem. Pure Sulphate Soda. | 10 | o | (3ijss). |
| Chem. Pure Phosphate Soda | 5 | o | (3j¼). |
| Chem. Pure Chloride Soda. | 2 | o | (grs. xxx). |
| Crystall. Carbol. Acid | 1 | o | (grs. xv). |
| Distilled (boiled) Water | 100 | o | (3iijss). |

Inject five to ten grams (3j¼-3ijss) of this solution every day or every third day.

† Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

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SATURDAY, MAY 12, 1894.


## EDITORIAL.

### THE D. HAYES AGNEW MEMORIAL.

When the REPORTER was called upon to chronicle the death of this great surgeon, it expressed the hope that "by the right of great powers and many virtues, and the beneficent uses made of them, Dr. Agnew's memory should be secured to other generations than that to which he belonged. He did too much for those among whom he lived and to whom he rendered unselfish service, for them, without discredit, to fail to build some tribute to his memory—something to further the great causes to which he devoted all the energies of his mental and moral faculties; something typical of his noble example, of the purity and courage of his life, of his unselfishness to his profession and to humanity."

"Hundreds of public-spirited men, who knew and loved Dr. Agnew in life and appreciated the stalwart manliness of his character, have a common interest and pride in his name and fame. It would be their pleasure, and duty as well, to aid such a work of love, honor and gratitude."

This hope seems now about to be realized and it is a pleasure to the REPORTER to give endorsement to the following:

The D. Hayes Agnew Memorial Committee, organized a year ago to secure a lasting memorial of Dr. Agnew in connection with the University Hospital, have pleasure in reporting that subscriptions have been promised of sufficient amount to give reasonable assurance of the speedy and successful carrying out of the project.

The plan includes not only the Children's Ward (for the building of which this Associate Committee was established and for which it is so earnestly laboring), but also an amphitheatre and ward class rooms, with wards for men and for women,—the whole to be a model in perfection of details and completeness of appliances, and thus a fitting representation of the wonderfully full and complete work of Dr. Agnew.

The State Legislature, at its last session, made an appropriation of $80,000 to the University Hospital for building purposes, provided that an equal sum of $80,-

000 be raised by the friends of the Hospital, and paid in cash, available for construction purposes. The Managers of the Hospital, appreciating the eminent propriety of our movement, have consented to give to the entire wing the honored name of D. Hayes Agnew.

Toward the additional $80,000 to be so raised, about $60,000 can now be counted upon as available in cash on or before May 1, 1894, leaving only about $20,000 more to be secured by that time, so that building operations may begin this spring, and the State appropriation be drawn and expended within the two years contemplated in the Act.

It is to be hoped that, in addition to the building fund, there may also be secured a sum sufficient for the beginning of an endowment. Such a memorial will best attest the affection inspired by Dr. Agnew's life of usefulness and the example of devotion to his profession, both as teacher and practitioner.

The grant by the Legislature is a recognition of the work done by the University and its Hospital, to which Dr. Agnew gave the best years of his busy life, and the subscription supplementing and securing that appropriation will show how his many friends, patients and students honor his memory.

All those who desire to join in this memorial of a great surgeon and good man can do so by sending their subscriptions to the Treasurer, Mr. Eugene Delano, of Messrs. Brown Brothers, at the banking house, southeast corner of Fourth and Chestnut Streets, Philadelphia.

By order of the Committee.

J. S. MacIntosh, D.D.,
*Chairman.*

J. G. Rosengarten,
*Secretary.*

Wm. Pepper, M.D.,
*Provost of the University.*

## THE MEETING OF THE STATE MEDICAL SOCIETY.

The ensuing week will be one of much interest to the medical profession of this state, as it will witness the annual session of the State Medical Society of Pennsylvania. The meeting this year was to have been held at Gettysburg, but circumstances compelled a change of place and the State Society accepted the invitation extended by the Philadelphia profession to become its guest.

Aside from the interest and importance of the meeting as a scientific body, preparations have been completed for the social entertainment of the visiting members and their friends. In addition to the usual courtesies, arrangements have been made for a theatre party, to be followed by refreshments, on the evening of Thursday, May 17th. The play will be "The Princess Bonnie" at the Chestnut Street Theatre.

Efforts are being made to enable the delegates of the State Society to accept an invitation extended by the Mayor and citizens of Asbury Park, N. J., to visit that famous resort and enjoy its hospitalties.

A year ago, at the suggestion of the Reporter, the citizens of Asbury Park extended an invitation to the American Medical Association to hold its meeting of 1894 at that place, and accompanied their invitation by a guarantee of remarkable inducements, but the Association accepted the invitation to the Pacific coast.

At the request of the Reporter, Asbury Park will again extend the invitation for the meeting of the Association for 1895, and the present invitation to the State Medical Society is to enable its members, and especially those who are to attend the San Francisco meeting, to see for themselves the superior attractions and facilities possessed by Asbury Park.

The Reporter would be glad to see such of its friends as may find time to visit its offices during their stay in the city.

# ABSTRACTS.

## OUR PRESENT KNOWLEDGE OF THE CURE OF MALARIA BY MEANS OF QUININE.

Professor C. Binz (*Cent. f. die Med. Wissen.*) states that just twenty-six years ago he opposed, in the pages of the *Centralblatt*, the then generally-accepted theory that the curative action of quinine in malaria is developed through the nervous system, and propounded the theory that quinine in all probability acts as a protoplasm poison on the pathogenic micro-organism, at that time undiscovered, which is at the root of all paludism. It has now been discovered that all forms of malarial fever are brought about by organism of the genus amœba, which penetrate the bodies of the red blood-cells, at whose expense they increase in size, finally sporulating and destroying their host. Laveran, who first discovered and described the parasite of tertian ague, also investigated the action of quinine on that organism, and found that when microscopical preparations of the parasite were treated with quinine, the vitality of the disease-germ was speedily destroyed, a fact which has been substantiated by Marchiafava, Celli, Grassi, and Feletti. The influence of quinine on the malaria parasites has also been studied by examining the blood of malaria patients before and after the exhibition of the drug. In this instance the investigations of Laveran, Romanoffsky, Bacelli, Golgi, Marchiafava, and Bignani established the fact that the parasites were killed by the quinine absorbed into the blood.

Dr. Mannaberg, who has recently investigated this question in the malarial districts of Dalmatia, Istria, etc., finds, among other things, that about three hours after the exhibition of from 7 to 15 grains of quinine, the amœboid movements of the amœboid form of the parasite of tertian ague slacken to a very perceptible degree, and that after a lapse of a further period of three to six hours, the number of parasites in the blood of the patient greatly diminishes, while many of those still left are torn and mutilated. On the full-grown parasite of tertian ague quinine either produces a complete cessation of all movement in the pigment, whereby the parasite acquires a glittering, cloddy appearance, as though coagulation had set in, or else dropsical swelling is set ), or, finally the parasite falls to pieces. Shortly after the exhibition of quinine, medium-sized parasites of tertian ague develop intense activity. It appears that quinine possesses a stimulating action before causing coagulation and immobility. This phenomenon has also been observed by Bacelli. According to Golgi, the medium-sized parasites of quartan fever acquire a glittering appearance and tendency to shrivel when the patient receives quinine internally; the large forms, however, become distended, their pigment exhibits lively oscillatory movements, and they frequently contain vacuolæ or abortive spores.

About three hours after the exhibition of a dose of 7½ grains of quinine, the nucleoli of some of the amœbæ of the milder forms of true quartan had either partially or entirely lost their tinctorial characteristics. After twelve hours of the treatment stainable nucleoli were hardly met with at all, most of the parasites having broken up into irregular fragments.

In those forms of malaria which are not curable by quinine that drug has no effect whatever on the parasites present in the blood. Bacelli, however, has found that many such severe forms which defy the ordinary method of treatment may be speedily cured by injecting the usual dose of quinine into a vein.

In spite of certain differences on minor points, Mannaberg and the other investigators one and all agree that quinine is a direct poison for the malaria parasite, and that the therapeutic doses employed are non-injurious to the cells of the human organism. Any assistance from the nervous system in the process of cure is neither evident nor necessary.

With regard to the prophylactic action of quinine, it is to be noted that the drug disappears very gradually from the blood and in an almost unaltered condition. By this means any young amœbæ and spores are kept in constant contact with the drug and are thereby checked in their further development. As to the part played by the leucocytes, it appears that phagocytism is prominent in cases of spontaneous cure of malaria, but not when quinine is employed. — *Provincial Medical Journal.*

## THE NECESSITY OF PROMPT TREATMENT OF TUMORS OF THE BREAST.

(H. R. Coston, M. D., in *Va. Med. Mo.*) The frequency with which one meets cases of cancer of the breast in its various forms is ample excuse for occasionally calling attention to its relief. During the last few months two cases have fallen under my observation which strikingly illustrate the necessity of more care on the part of physicians in dealing with cases of "tumors in the breast."

A tumor situated anywhere in this gland should always be looked upon with suspicion. However small it may be, it does not relieve doubt of its malignancy. Although not larger than a split pea, it may be the beginning of a slow and painful death if not promptly and vigorously treated.

Carcinoma is regarded by most authorities at the present day as primarily a local disease. Remembering that 90 per cent. of all tumors of the breast are malignant, how imperative it is that the family physician be prepared to give the family and patient the proper advice.

Let us see what a few of the recognized authorities on this subject have to say in regard to the treatment of such cases.

Treves (Operative Surgery) says only 5 per cent. die of the operation.

Gerster says the large number of relapses and high death rate are due to the tardiness of the family physician in advising operation, and the failure of the patient to heed the advice.

His mortality has only been 3 per cent. after operations for the removal of the breast (*Aseptic and Antiseptic Surgery*).

Again, hear this: "The greatest physical evil which can befall a human being is to become infected with malignant disease. * * * The rule should be held imperative that all cases which, after a short trial of remedies, still remains doubtful, should at once be subjected to the knife."—Holmes' *System Surgery,* Vol. III, page 709.

A tumor of the breast occurring after the thirtieth year in either sex, should be excised as soon as discovered.

Gross had a mortality of only 3.7 per cent. of all cases operated, although he often removed large portions of the pectoralis major muscles along with the gland. He has an absolute cure in 21 per cent. of *all* cases.—*Am. Sys. Sur.*, Vol. II, page 319.

The treatment of cancer can only be undertaken by the surgeon since, up to the present time, all the specifics introduced, either by regular practitioners or by charlatans, have proved quite inefficient, if not harmful.—Quain *Dic. of Med.*, page 104.

Thomas Bryant, of London, has a mortality of only 6.7 per cent., and only 3 per cent. of the whole were attributable to the operation.—*Surgery*, page 778.

J. D. Bryant says 9 per cent. never have a recurrence, and an average of one year is added to the life of cases in which there is a recurrence.—*Oper. Surg.*, page 480.

The above are sufficient quotations to show what the present opinions of men, whose ability cannot be questioned, are. And they also show what the prognosis is, both as regards the immediate effect and the prognosis as regards a return of the disease. I could go on citing authors *ad infinitum,* but it is useless. With the present lights before us, no one should hestiate, when a case of tumors of the breast is presented to him, to immediately recommend its removal.

But there are many who, notwithstanding all this, hold up their hands in holy horror and say: "Keep your hands off that lump." A case in point I have now under obsetvation.

Mrs. W., aged 34, came to me two years ago with tumors the size of a hen's egg in each breast. I immediately recommended their removal, together with the axillary glands, which were then becoming enlarged. The woman was willing and anxious for an operation, but the husband objected, and said they would go home and "write" me about it. That was the last I heard of the case until a few weeks ago I was asked to see her, when the case was simply hopeless from extension and systemic infection. It then developed that the family physician had urged them to have nothing done.

A second case just similar has just died and left a houseful of little children to be reared motherless.

Now, in such cases, what a responsibility the family physician takes upon himself when he says: "Have nothing done to that tumor." Take the first case; two years and more have elapsed since the woman first presented herself for operation. It was then, without doubt, a local disease, and thorough removal would have freed her from the disease, and saved her a slow, painful death. We all know that it is *always* a fatal disease without operation; and even should only 9 per cent. have a perfect recovery, it is just nine out of every hundred cases saved from a most loathsome disease and slow and exceedingly painful death. But it is unfair to make 9 per cent. the standard, for there are those who have a perfect result—namely, never a recurrence—in 21 per cent. of all their cases.—(Gross *loc.cit.*) In the event that the disease should recur, we have shortened the stage of ulceration by so much time as may elapse between the operation and its recurrence. Even this is a great gain, as it relieves the mind for a certain length of time and saves the patient and friends much mental worry.

Should the tumor be one of benign nature, no harm would be done the woman, and she would be saved the risk of its degenerating into one malignant in nature.

To sum up, we may say: *Every* tumor developing in the breast in either sex, at whatever age, should be at once extirpated and the glands of the axilla removed with the breast and pectoralis major in cases of extended disease.

The *facts* should be set before the patient in a truthful manner, neither exaggerating the hope of an absolute cure or the immediate dangers of the operation.

## ACUTE MUSCULAR ATROPHY OF THE SHOULDER FOLLOWING A TRAUMATIC INJURY TO THE CRANIUM.*

Dr. V. Idzinski reports (*Wiener Med. Presse*, No. 52, 1893): The patient, aged 24, soldier, received an injury to the skull in the right parietal region; the bone had not been exposed. Two weeks later he noticed a decided weakening of the left shoulder, which increased rapidly and necessitated his admission to the hospital some weeks later. An examination showed a marked atrophy of all the muscles of the left shoulder—sensation, pressure, or temperature unimpaired.

Sensation for pain normal, skin and muscle reflex unimpaired; at no place painful spots.

The author diagnosed the case one of cerebral atrophy, which he based upon the following conditions present:

1. Anatomically—the injury was in the region of the motor centres and corresponds to the right sulcus centralis.

2. The atrophy developed in this region and followed the laws adopted, by extending to the left side, or opposite side.

3. The diagnosis was verified by exclusion of all other diseases.

Anatomically, the author believes that a molecular change took place in the brain substance as a result of the injury.—*Centralb. f. Chirurg.*, No. 8, 1894. W.

* Translated for THE MEDICAL AND SURGICAL REPORTER by M. B. Werner, M. D.

### Barbers' Itch.

*Chem. and Drug.* gives this formula:

℞
Ichthyoli..... gr. xx.
Acidi Salicylici..... gr. x.
Hydrarg. Oleat. (10 per cent.)..... 5ii.
Olei Lavandulæ..... m iii.
Lanolini..... 5vi.

M. Sig. Keep constantly applied to affected parts.

### Tubercular Abscesses.

Billroth treats tubercular abscesses as follows:

℞
Iodoformi..... 5ii.
Glycerini..... 5iiss.

M. Sig. After evacuating the pus, inject into the abscess cavity.

### Hemorrhoids.

℞
Iodoform..... 5ij.
Acid. Tannic..... 9j
Ext. Belladonnæ..... gr. xv.
Vaseline..... 5j.

M. F. ungt.
Sig. Apply on cotton tampon.

# SOCIETY REPORTS.

## THE CLINICAL SOCIETY OF LOUISVILLE.

*February 13, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### MONSEL'S SOLUTION IN THE TREATMENT OF DIPHTHERIA.

DR. P. GUNTERMANN: I want to give my testimony to a drug that I have used for the last two years exclusively in the treatment of diphtheria, *i. e.*, the local application of the sub-sulphate of iron (Monsel's solution). Since the report of some physicians from Bowling Green, before the Kentucky State Medical Society, I have treated all cases of diphtheria with this solution, and in no case have I seen any trouble, and they have all gotten well. The statement of the Bowling Green physicians was to the effect that they had treated 250 cases by this method with only one death. I have treated in all about eighteen cases with Monsel's solution, with no deaths thus far. I was called to see the last case three or four days ago; the attack was a very severe one, but after the second application of Monsel's solution the membranes separated and the child has rapidly convalesced. In another family of three children, the oldest, aged about eight years, died of diphtheria, pronounced so by the attending physician, and also by one of our most prominent specialists who was called to do an intubation. Everything seemed to be all right, but the child died. I was called afterwards to treat the surviving children suffering from the same disease, and under the use of Monsel's solution they made rapid recoveries.

I simply wish to give my testimony in favor of Monsel's solution in the treatment of diphtheria, confirming the statement made by others before the State Medical Society. Since the results have been so favorable, I have used nothing else. It should be employed liberally and often. I make a mop like a brush of absorbent cotton, saturate it with, perhaps not less than a dram of the solution, and swab out the throat thoroughly.

#### DISCUSSION.

DR. J. W. IRWIN: I have listened with a great deal of interest to the remarks made by Dr. Guntermann concerning the use of Monsel's solution locally in the treatment of diphtheria. I was trying to think just when I had made use of that drug myself, and I recollect now that it was in the spring of 1874. I was called to see a few cases of diphtheria in the country, about twenty-six in all, in a little village near Evansville, Indiana. Four or five children died in one day. They had been sick for two or three days only, it being a very malignant form of diphtheria. I had just read an article written by somebody in Pennsylvania, who had spoken of the wonderful effect of Monsel's solution in diphtheria and like every new thing it was lauded to the skies. I applied Monsel's solution of full strength. In those days absorbent cotton was not as much in use as now, and I do not think at all, at any rate I used sponges; I saturated them with Monsel's solution and had applications made three or four times or oftener each day. Out of the twenty-six cases which came under my observation at that time, not in a dying condition when I was called, twenty-one of them recovered. I then thought it was an important thing to know that we had such a powerful and effective remedy against diphtheria. In the next cases I saw I was less fortunate with the use of Monsel's solution; there were three children taken ill in one family and all died notwithstanding the prompt use of Monsel's solution. The fourth child was not taken ill at the time the others were, and I thought certainly Monsel's solution applied early in that case would prevent its taking the disease at least in a violent form. A few days later this child, about six years of age, was taken ill and Monsel's solution (Squibb's) was used in full strength, to which solution ten per cent. of pure carbolic acid was added, believing in the germicidal effect of carbolic acid, as it was shortly before that time Sir Joseph Lister had made his well-known experiments with carbolic acid, and the idea of antisepsis was prevalent. Neither Monsel's solution nor carbolic acid had any effect in arresting the disease, notwithstanding the fact that both were faithfully applied when the membrane first appeared as a minute patch. The case went on from bad to worse until the child died, and thus four children in one family died of diphtheria notwithstanding the solution of sub-sulphate of iron was faithfully applied locally, and to which had been added ten per cent. of pure carbolic acid. I then lost faith in the local application of Monsel's solution as a panacea in the treatment of diphtheria. I found, however, that it had a place, not as a panacea or real curative agent, but it had the effect of lessening the deposits in the throat that were not too much attached, and by its local effect the patient was enabled to swallow immediately

after its use. For this reason I consider it an important remedy in the treatment of diphtheria, as it frequently happens where the tonsils and the arch of the soft palate are involved, as I have often seen, that the patient cannot swallow, but after the use of Monsel's solution this may be accomplished.

So that my experience with Monsel's solution in diphtheria without any other application has not been as favorable as the Bowling Green doctors have suggested. It has a place in the treatment of diphtheria; but I would advise that the fellows act very cautiously in using it, inasmuch as it is a very powerful astringent, and in the cases of young children it is often very exhausting to them, causing difficulty in breathing, and the shock after its use, especially when they have to be held while applying it, is often very injurious to their welfare.

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SOME REMARKS CONCERNING THE WORK OF DR. MARTIN.

DR. C. G. LUCAS: I have concluded this evening to occupy your time for a few minutes in speaking of the work I saw abroad, particularly of Dr. Martin, of Berlin, with whom I spent two months some time since, and of all gynæcologists I have ever seen, either in this country or abroad, I regard him as the best. He has a large four-story hospital located on a rather prominent street of Berlin, and has his own clinic. In this hospital he has an outdoor department as well as indoor, and at two periods in the year, May and September, he accepts private pupils. At the close of the year I was with him. His class numbered about thirty, not only Germans, but Americans, Englishmen, Frenchmen, Russians and I think two Italians. He was able to speak all these languages with sufficient fluency to get along very well. He was raised in England and has very good command of the English language. He has a large lecture-room, which is also used as a general examining room and two operating-rooms on the floor above. In one room he does all of his minor work, the other he uses entirely for his abdominal surgery. When he has abdominal sections on hand, all students are required to take off coat, vest, collar and cuffs and pass through a room in which a carbolic acid spray is playing. The patient is brought into the operating-room which is divided by a chain, and placed on the table, naked. For anæsthesia I never saw him use anything but chloroform. He has a chief assistant, Maekenrodt, who sits down on the left side of the table; then an assistant at each end, one who gives the anæsthetic, and another who takes down the history of the case, age of the patient, condition for which operative procedure is resorted to, etc., and the time it takes to do the operation; then he has two nurses. One, Frau Horn, has been with him a great many years and I think is the best nurse I have ever seen.

Dr. Martin in stature is a very large man. In operating he always sits down, his table being divided into four parts, and so arranged that one portion of it can be dropped to allow the bandage to be applied to the patient after the operation is over. He believes in operating rapidly, because he says the longer the patient remains on the table the greater the shock. He makes a very large incision, and just as soon as the incision is made the abdominal cavity is packed with large flat sponges which absorb all fluid and hold the intestines back. He then removes an ovary for instance, and the trained nurse hands him a needle threaded with sterilized cat-gut with which he transfixes the pedicle, ties off the tube and then removes the other ovary if necessary in the same manner. He never uses irrigation of any kind. When he is through with removal of the appendages, the nurse hands him another needle holder complete; he inserts the first suture and it is tied; she then hands him another which is introduced and tied in the same manner. As fast as each suture is introduced it is tied, and in that way he is enabled to operate with great rapidity. I have seen him do an ordinary ovariotomy in four minutes from the time the patient went on the table until she was taken away with the operation complete. I saw him do seven laparotomies in one hour and forty-five minutes altogether. In doing an hysterectomy he removes the uterus entire, that is in a complete abdominal hysterectomy. Vaginal hysterectomies are done by him every day. In abdominal work, which was probably four or five times per week, by the very fine method of postal service in Berlin he was enabled to notify all students to be present at an operation at an early time any day, if they had not been notified the day before. In doing a vaginal hysterectomy he first makes an incision through the *cul-de-sac*, then packs iodoform gauze in the vagina, ligating the broad ligament as he goes along, removes the uterus entire and closes the wound, using cat-gut altogether. He never had any bad results from the use of cat-gut; never uses a clamp. He is a great believer in colporraphy, in fact I have seen him do as many as eight and ten in one morning. In this operation he always makes a diamond-shaped incision, and uses a knife that was invented by his assistant, Frau Horn. It is something the shape of a card-club made of very thin steel, and by using tissue forceps he could pick the mucous membrane up, and rolls the whole thing out. He then sutures through the center of the diamond from above down, takes up about one-third of the tissue; the

next row of sutures from below upward completes the operation, operating under a stream of bichloride of mercury 1 to 10,000. After these cases are operated upon they are taken into another private room where the dressings are applied. I saw him do at least a hundred of these operations, none of which was followed by suppuration. He preserves complete records of all his cases by means of books especially prepared for the purpose. His results are very good comparatively; I think his percentage of deaths are perhaps a little higher than among other German operators, but this I attributed to the crowding of patients in his room and the condition they were in at the time of the operation.

In his touch course I have seen a great many patients examined in one day. A patient would be brought into the room, the students divided into classes of five, each member of the class has a chance to make a diagnosis of every fifth case and an examination of every case. That diagnosis is then either confirmed or disputed by Dr. Martin himself, and if it is an interesting case the condition present is outlined on the board with crayon, then the other class is entitled to examine it. If necessary the patient is anæsthetized in order to allow a more thorough examination.

At the time I was there Dr. Martin was considered to be the best gynæcologist on the Continent. He does not believe in electricity, but uses the knife altogether. He is very courteous to Americans, at least I found him so.

There are a great many other courses in Berlin, one particularly worthy of mention is under the control of Dr. Olshausen. He has a very large out-patient department; with five examining tables and two tables for treatment. While I was there his classes were divided into threes, each man having a chance to diagnose every third case; then Dr. Winters, Prof. Olshausen's assistant, would do exactly like Dr. Martin, either confirm or dispute the diagnosis. In other departments they inserted pessaries, or washed out the uterus as the cases might demand. On Fridays all these chairs would be occupied by cases under anæsthesia, and some very interesting ones are encountered. Cases of abdominal tumors, double pyosalpinx, etc., etc., and every man has a chance to do some gynæcological operation. I saw Prof. Olshausen operate upon one case of double pyosalpinx in the Trendelenberg position, where the adhesions were so great that he tore into the rectum twice. He has a very large operating-room, the floor and walls of which are covered with tiling. He operates as a rule on an ordinary table. He is not a very rapid operator, but usually does his work very nicely. In vaginal hysterectomy as well as minor gynæcological work, his operating-room is so arranged that every man has a chance to see.

I also saw considerable surgical work in England. In one case where an amputation of the cervix was about to be done, the operator had occasion to introduce the sound to steady the uterus, and immediately after withdrawal of the sound a fœtus popped out. They were quite surprised, but went on and finished the operation, then concluded to introduce the sound again, when another fœtus popped out. I saw some very bungling work among the London surgeons, as well as bad diagnosis. One case was operated upon for ovarian cyst; the patient had ceased menstruating some fifteen months before, and had expected to be delivered in January.—About the middle of December she had some little flow and called in a doctor who said nothing was necessary and left her. She had passed the time she expected to be delivered and about the first of April had another flow which continued for three weeks. Nothing was done for her, and she went along until the first of June, when she had a perfectly normal menstrual period. On the Fourth of July when the ovariotomy was done, they found a perfect extra-uterine gestation, the child being very large. The patient recovered and there was no further trouble.

I remember reading several days ago the report of an operation done for cancer of the stomach which brings to mind a case that I saw Mr. Jessop, of the Cancer Hospital, operate on. The patient was a woman thirty-five years of age. Her stomach had been washed out for several days before the operation with a solution of salicylic acid. After the incision was made the cancerous mass was extirpated; the cut surfaces of the stomach and duodenem were inverted and closed with Lembert sutures. A Senn plate was introduced into the stomach and another into the jejunum, sutures tied and abdominal wound closed. In thirty-six hours the patient was taking milk and beef tea and her recovery was entirely uneventful.

I was quite surprised at the manner in which Lister operated; I saw him operate quite a number of times, and he did not even take the trouble to clean his finger nails, but would immerse his hands in a solution of carbolic acid; yet I never saw any bad results following his operations.

So far as my experience leads me to believe, I think the gynæcology at Berlin is superior to that of any other city abroad; for general surgery I think Vienna beats them all.

DISCUSSION.

DR. W. H. WATHEN: Probably I am more interested in the report of Dr. Lucas than some of the other Fellows, because I am personally acquainted with Dr. Martin, having met

him in this country several years ago. While we may not follow Dr. Martin's methods in all particulars I doubt if he has a superior in gynæcological work. Like all of us he has his hobbies, which at times may be carried too far, and he may have bad results or deaths, where perhaps a different method might have been productive of successful results.

I am a little surprised at the remark by one of our Fellows, that pus tubes so often follow his curetting operations, and I feel sure that if such be true, it is because of a lack of antisepsis before or during the operation, for I do not believe there is danger of pus tubes following a thorough curetting of the uterus, if proper precautions are observed. If infection is not by contact there is practically no danger of sepsis being conveyed to the patient from the room or clothing.

During the last two years I have done a great deal curetting for inflammatory and other conditions of the endometrium, and for malignant disease, without the slightest evidence of any immediate or subsequent bad results, but I observe as rigid aseptic and antiseptic precautions as in a laparotomy. The patient is prepared after the same fashion: A hot vaginal douche is followed by a douche of bichloride solution 1 to 2000. After the patient is on the operating table the vulva and vagina are thoroughly washed with a 1 to 1000 bichloride solution. The speculum is then introduced and the vagina wiped dry with gauze or cotton sterilized in and wrung out of a 1 to 1000 bichloride solution. The neck of the womb is cleansed as far as possible with the bichloride solution; all the instruments and gauze used for tamponing are made aseptic in an Arnold's sterilizer. The neck of the uterus is dilated sufficiently to allow the curette to go in easily. I use the sharp curette; the uterus is pulled down by fixation forceps. Beginning at the fundus I curette the body first taking every particle as I proceed and go around the uterus two or three times, until I am satisfied all diseased tissue has been removed. I then curette the neck thoroughly, because I find in many cases the neck is the part containing the most infection. After curetting, the uterus is irrigated with a 1 to 5000 bichloride solution and the cavity tamponed not tightly, but well, with iodoform gauze; the vagina is also tamponed lightly with iodoform gauze. The gauze in uterus and vagina is removed in two days, and a vaginal douche of a 1 to 4000 bichloride solution given. On the third day the patient is allowed to get out of bed and a few days later she is able to go home. I have never used carbolic acid as an antiseptic, and do not think its use is indicated. Demonstrations made by bacteriologists and pathologists have shown that it is of very little use as a germicide. Bichloride of mercury has been proven to be the best antiseptic we have for practical use, and in these cases it is harmless and the results in my experience have been good.

In cancerous disease I curette frequently for the purpose of removing the necrosed tissue and to bring about a more healthy condition by curing the patient of disagreeable symptoms, such as offensive discharges, hemorrhages, etc. When I do a vaginal hysterectomy I always curette thoroughly three or four days before the operation. All the necrosed tissue is gotten away, and the vagina is tamponed; just before the operation I again curette and irrigate with bichloride solution, and I am sure when I open the peritoneal cavity and remove the uterus that I will not convey septic matter from septic tissue. I use no sponges in these operations; I use sterilized cotton that is kept for fifteen to thirty minutes in 1 to 1000 solution of bichloride, is wrung dry and the blood wiped away with it. I use cotton or gauze in all my plastic operations, such as colporraphy, perineorraphy, etc., and have no pus and get primary union.

DR. S. T. BULLOCK: In the last few years at the University we have almost daily practiced thorough curettage of the uterus for chronic inflammatory troubles, which operations are done before the class at the clinic. In cases where septic trouble has followed parturition, we do not use the sharp curette, but in all other cases this is the instrument employed. We take every possible aseptic and antiseptic precaution, and after curetting, in addition to irrigation with antiseptic solution, we ordinarily swab the uterus with tinct. iodine, then pack with iodoform gauze of course, first as Dr. Wathen has said, dilating the uterus with Hank's dilator. If the sharp curette has been used the patieut is usually sent home in a carriage, if otherwise they frequently, after remaining for some hours, are allowed to ride home in the street car or other mode of conveyance. I have charge of the records and have followed these cases very closely, and we have never yet had any bad results following these operations.

### CASE OF DIPHTHERIA.

DR. P. F. BARBOUR: Two months ago I was called to the Children's Hospital to see a child with the history that for three days previously there had been fever and some discharge from the nose. Upon examination I found a small patch, which I diagnosed diphtheritic membrane, in the pharynx posterior to the child's right tonsil. I inferred that the sanious discharge probably came from a diphtheritic membrane in the nose, and my opinion was confirmed by the subsequent progress of the case. I immediately had the

child isolated and for treatment gave tincture of the chlorid of iron 7½ minims every two hours in glycerine. On the fifth day laryngeal symptoms developed and I had Dr. S. G. Dabney intubate. With the intubation I added this treatment: Bichloride of mercury in 1-60 grain doses every two hours, also whiskey, two drams in two ounces of milk. From that time the child received 7½ minims of the tincture of iron, 1-60 grain of bichloride of mercury every two hours, and two drams of whiskey with two ounces of milk. At the same time his nose was syringed out with peroxide of hydrogen solution, 1:4, in which a little bicarbonate of sodium was dissolved. I used the Oakland Co's peroxide of hydrogen, which is supposed to be the least acid of all the preparations, but upon testing it I found it was distinctly acid, therefore dissolved in it a small quantity of bicarbonate of sodium to neutralize the acidity. The seventh day after introducing the tube we attempted to take it out, and did remove it but the child breathed with such difficulty that the tube had to be introduced again. On the tenth day it was coughed out and with it a large piece of membrane, after which the breathing was perfectly free. While the tube was in the throat the child developed purulent otitis media; there was suppuration from both ears. The fever remained high long after the tube was removed.

Of course the case is not especially out of the ordinary, except that there was so much diphtheritic infection, and yet the child recovered. The interesting point to us was that after the removal of the tube the child continued to have fever; it would run up to 103° or 104° F., and once 105° F. was registered. We could find no cause for this because the ears were discharging very freely, and there was evidently no pent-up pus. An examination of the spleen revealed no enlargement; the fever was evidently not malarial, for the child still maintained this high temperature for two or three weeks even under large doses of quinine. The child was only about two and a half years old, and he took from eight to eleven grains of quinine per day, which would have been sufficient to have controlled malarial fever in a very short time. There was no reason to suspect tuberculosis though the child had a scrofulous diathesis. Another interesting point to me was that we gave him rectal feeding. I used for the enema one egg with fifteen grains of salt rubbed up in it; this was given every four hours, and was retained without any trouble. We tried the enema advised by Ringer, port wine with beef, but the child was not able to retain this more than twice. The alcohol seemed to irritate the rectum so it could retain nothing at all.

We did not examine the membrane for the bacillus of diphtheria. Two weeks after the tube was removed, all the membrane so far as we could see had disappeared. We examined the nasal secretions and found no Klebs-Loeffler bacilli at that time; at the end of the third week we again made an examination simply as a precautionary measure before returning the child to the ward; and found no bacilli of diphtheria in either case.

To the conscientious and careful nursing of the two nurses should be given much of the credit of the successful result.

DISCUSSION.

DR. J. W. IRWIN: The case is interesting from two points of view:—first, the age of the patient, and the severity of the disease; second, the extension of the diphtheritic disorder to the nasal passages and middle ear, followed by recovery. I have never seen a case of diphtheritic trouble with anything like the complications reported to get well. The cause of the secondary fever would be a very interesting point to know, for, as a rule, in diphtheria we do not have much fever after the first few days, the tendency is usually more toward depression. The case was certainly carefully managed, and the treatment proved to be effective. I think it is likely that the diagnosis of the case was correct. A case of that magnitude with no sequelæ such as local or general paralysis is also worthy of note, and it may possibly be in that case that the antiseptic treatment prevented it. Another interesting feature in the case is that the deposit had been examined for the bacillus and none found, as it frequently happens that the bacillus can be found for a much longer period than three weeks. The French Academy of Medicine have recently declared that it takes forty days for the contagion of diphtheria to disappear from a patient, and it recommends isolation for that length of time.

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HYPERPYREXIA IN A CHILD TWENTY MONTHS OLD.

DR. T. S. BULLOCK: I was called yesterday morning to see a child twenty months old, with the history as given by the father, of the child having had a convulsion shortly before. I found the child having clonic convulsive movements of the right side, and when I touched it was impressed with the extreme heat of the surface, and in taking the axillary temperature was surprised to find that it registered 108°F. I immediately gave the child a cold bath and an enema of bromide and chloral, also gave chloroform to ward off a general convulsive seizure. The convulsions, however, on the right side soon became tonic, the left side soon became involved in a clonic convulsive spasm and the child died last night at eleven o'clock, never regaining consciousness.

The case is interesting to me because of the excessive hyperpyrexia, being the highest I have ever seen.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

for May. Dr. George M. Edebohls contributes a paper on

**Diagnostic Palpation of the Vermiform Appendix.**

The author has been practising palpation of the vermiform appendix for somewhat over a year. Practically all of his experience, he states, has been gained upon women, only three cases of appendicitis in the male having, during that time, come under his observation. Palpation is best performed in the following manner: After completion of the ordinary bimanual examination of the pelvic organs, the woman is drawn upward upon the table to the extent of a foot or two, her feet still remaining where they were placed for the vaginal examination. This is done for the purpose of unfolding the flexures of the thigh, and rendering the right inguinal region more accessible to the palpating hand. One hand only, applied externally, is required for the practice of palpation of the vermiform appendix. No assistance can be rendered by a finger in the vagina, and very little assistance, and that only occasionally, by a finger introduced into the rectum. The examiner stands at the patient's right and begins the search for the appendix by applying two, three, or four fingers of his right hand, palmar surface downward, almost flatly upon the abdomen, at or near the umbilicus. The examining fingers are passed over the abdomen, in a straight line from the umbilicus to the anterior superior spine of the right ilium, and the character of the various structures noticed as they come beneath and escape from the fingers passing over them. In doing this the pressure exerted must be deep enough to recognize distinctly, along the whole road traversed by the examining fingers, the resistant surfaces of the posterior abdominal wall and of the pelvic brim. The author asserts that the whole secret of success in the practice of palpation of the vermiform appendix lies in the fact that pressure must be made deep enough to recognize distinctly the posterior abdominal wall, the pelvic brim, and the structures lying between them and the examing finger.

The author states that the organ is recognized as a more or less flattened, ribbon-shaped structure when quite normal, or as a more or less rounded and firm organ, of varying diameter, when its walls have been thickened by past or present inflammation. When it is the seat of inflammatory changes the appendix is always more or less sensitive on pressure; the normal appendix exhibiting no special tendencies on being squeezed. A good guide; in searching for the appendix, is formed by the right common and external iliac arteries, the pulsation of which can be easily and plainly felt. The appendix is generally found almost immediately outside of these vessels. At its base it is separated from the vessels by a space of one-half to one inch, while lower down in its course it generally crosses very obliquely the line of the arteries.

Theoretically, two conditions mainly militate against the successful palpation of the vermiform appendix after the method above described, namely, the variable situation of the appendix and its frequent location behind the cæcum. Practically, the author has found that these difficulties in the way of diagnostic palpation are not so great as one would suppose.

As the result of these observations the author would lay down a broad rule in regard to operating in appendicitis: Not to operate in chronic cases unless the diseased appendix can be felt, nor in acute cases unless by palpation the diseased appendix or the presence of a tumor can be recognized. Anæsthesia may be necessary, in exceptional instances, to decide the question.

Dr. Reynold W. Wilcox discusses

**Uræmic Hemiplegia,**

presenting the following conclusions:

1. Uræmic hemiplegia is a distinct form and should be recognized as such.
2. The peculiarities are its mobility, variability, and complete recovery.
3. The diagnosis rests upon antecedent history, condition of the urine, and temperature curves.
4. The dominating factor in the treatment is the uræmia.

Dr. John K. Mitchell contributes a paper on

**The Effect of Massage on the Number and Hæmoglobin Value of the Red Blood-Cells.**

The author sums up the results thus: In health, massage increases the number of red corpuscles, and to a less degree and not so constantly their hæmoglobin value. In all forms and grades of anæmia there is a very constant large increase in the number of the red corpuscles after massage; this is greatest at an interval of about an hour, after which it slowly decreases. This decrease is postponed more and more if the manipulation be daily repeated. An improvement also takes place in the general tone of the circulatory and muscular systems. There is an occasional but inconstant increase in the hæmaglobin value, and this increase is proportionately less great than that of the cellular elements.

Massage is of great and certain value in high-grade anæmias and is without danger in such cases, no matter how feeble. It is evident that the present definitions of anæmia are insufficient. An essential part of the description in all of them is that there are defects of number, of color, or of both, in the blood. This is not necessarily or always true. The fault may lie in a lack of activity or of availability in the corpuscles. Lastly, neither an anæmic appearance nor a blood count is alone enough for a certain diagnosis. Other

signs must be used as a check on the blood examination for the establishment of the existence of anæmia. The white blood corpuscles have not received sufficient attention in this study, although it seems as if in most cases they were increased as well as the reds.

Even in direct anæmia caused by hemorrhage, massage may be a valuable aid in the treatment both by the impetus it will give to the cells indisposed or disabled for free movement, and by the stimulation of the making of corpuscles. The author has hopes soon to publish some facts as to the application of manipulation to such disorders.

The excess of blood brought into the circulation by massage may be one of the reasons why in occasional sensitive patients we see such discomforts as headache follow its use. Practically we have added a certain number of millions of cells to their tissues, and need not be astonished if some signs of plethora result.

It is evident that massage has complex effects and that the numerical increase of the corpuscles, the added hæmaoglobin value, and the better circulatory and muscular tone, may be due to many causes operating together—a vasomotor nerve stimulation, a direct hastening of the venous currents, an indirect hastening of arterial flow, an improved metabolism, are only some of them.

Dr. George W. Crary presents a paper on

**Myxœdema, Acquired and Congenital, and the Use of the Thyroid Extract.**

The author states that we must bear in mind that in treating congenital myxœdema we have not a pre-existing condition to which we can bring back our patients; but that in these cases the first step in the treatment is to restore the child's health, and the second step is to maintain the child in a normal condition, so that the development of its mind and body will progress as in any other healthy child of the same apparent age. That such development will take place, he feels sure; but until the cases have been kept under observation and treatment for some years, absolute proof cannot be had. It is his belief that if we break away from the term cretinism, with its vivid picture of the "pariah of Nature," and look more closely for the symptoms of myœdema, we will find that many so-called idiots, imbeciles, cases of arrested development, etc., among children, are in fact cases of functional inactivity of the thyroid gland, and hence susceptible of treatment by thyroid extract, with improvement, and perhaps even cure.

He sums up the effects of thyroid administration as follows:

Increased matabolism; shown by—

1. Elevation of temperature.
2. Increased appetite, with more complete absorption of nitrogenous foods.
3. Loss of weight, with nitrogen excreted in excess of that taken in the food.
4. Growth of skeleton in the very young.
5. Marked improvement in body nutrition generally.
6. Increased activity of mucous membranes, skin and kidneys.

The rheumatic symptoms and the anæmia are not only not relieved, but are most frequently aggravated.

Dr. F. Parkes Weber contributes a paper on

**Muscular Cramp, in Relation with the Phenomena of Angina Pectoris and "Intermittent Claudication of the Extremities."**

An explanation of ordinary muscular cramps (such as those sometimes affecting the legs of healthy persons after violent exercise and at night time) is that they are due to the irritation caused by the accumulation of waste products in the affected muscles. By the waste products the endings of the centripetal nerves in the muscles are irritated and the cramp or tetanic contraction is a reflex result. The author gives the chief points of his paper as follows:

"True angina pectoris has long been separated from the nervous cases, or 'pseudo-anginas;' it has been regarded as due to stenosis of the coronary arteries and as analogous to certain premonitory signs of dry gangrene, due to stenosis of arteries in the extremities. In the present paper he does not pretend to have discussed these questions in their entirety, but has confined himself to the role played by muscular cramps in relation to the other phenomena. In this paper it is maintained that muscular cramp does not take any necessary part in angina pectoris or in the phenomena preceding senile gangrene in an extremity, but that cramp is likely to occur in any muscle where an accumulation of waste products takes place, whether this accumulation be caused in healthy muscles by rapid catabolism due to excessive exercise, or by insufficient removal of the waste products in the cases of disease due to stenosis of the main arteries and consequent diminution of the blood stream through the affected part. It is further held that these cramps, when they do occur in angina pectoris, are expressed by the syncope, which may accompany the attack and lead to a fatal termination."

**Compound Tincture of Coal Tar**

is described by Dr. Louis A. Duhring. Summing up the result of his investigations, the author concludes:

1. That the best tincture of coal tar is made with the aid of tincture of quillaia.
2. That the strength of the tincture of quillaia should be 1:4, with 95 per cent. alcohol.
3. That the coal tar (1 part) should be digested with the tincture of quillaia (6 parts) with frequent agitation, for not less than eight days, and preferably for a longer period, and finally filtered.
4. The resultant product is a brown-black, clear tincture, which upon the addition of water forms a cleanly yellowish emulsion, the color and certain other characters varying with the kind of coal tar employed.
5. The tincture is stimulating, and is prescribed usually largely diluted, with from 10 to 60 parts of water, as a wash, and is useful where tar is indicated, as in certain forms of eczema, psoriasis, pruritus, and in other inflammatory diseases of the skin. It is often more useful when employed weak than strong.

This preparation, which may be designated as "compound tincture of coal tar," takes the place of several similarly composed proprietary preparations, known as "liquor carbonis detergens," and "coal-tar saponine."

**The Cultivation of the Tetanus Bacillus**

is described by Langdon Frothingham, M. D. V. To obtain pure cultures of the tetanus bacillus from cases of traumatic tetanus, or experiment animals, the following method is recommended:

1. Inoculate alkaline bouillon with the pus from the wound, or pus being absent, small bits of tissue from the inside of the wound; or in experiment animals inoculated with pure cultures, bits of tissue from the region of the point of inoculation are used.
2. Place tubes in an atmosphere of hydrogen and in the breeding oven for forty-eight hours.
3. Examine microscopically, and if tetanus bacilli are present—
4. Heat from three-quarters of an hour to an hour in water-bath previously heated to 80°C.
6. From heated tubes inoculate fresh bouillon, and place in thermostat under hydrogen for forty-eight hours.
6. Test purity by microscopic examination and cultures in gelatin, agar, etc.
7. Test virulence on mice, white or gray.

The remaining paper in this issue is the report of "Eight Cases of Beri-beri," by Henry C. Boenning, M. D.

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THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

for April. Dr. Adrian Hava writes of

**Spontaneous Combustion of the Human Body.**

His subject refers to instances where persons, usually old, fat, and addicted to alcohol, and always complaining of cold, have been found dead or dying, and partly burned up, usually burning when found. In some cases this has led to trial of others for murder, and such a case is mentioned.

In common with most of those writing about this subject, the author originally believed that the fire was due in some way to the alcohol consumed; but in trying to prove that this might be so, he found that a body soaked for some time in alcohol, and with the veins then injected with alcohol, would not burn. The alcohol, of course, could be set on fire and would burn for some time, but would leave the body intact. Also, animals, poultry, etc., to which a quantity of liquor was given daily for some time would yield alcohol after death only if it had been given for the last time very shortly before death. The reason for this is that the alcohol is absorbed by the tissues only as carbonic acid and water.

The other prominent peculiarity of the victims of this strange accident was complaint of chilly sensation and drowsiness resembling alcoholism: all of them used to sit near a furnace or charcoal brazier, and the author found that the symptoms of poisoning by carbon monoxide, the fumes given off from charcoal, were (in a person habituated to it) prostration, chilly sensations, bronchial irritation, redness of face and skin, irresistible desire to sleep; finally insensibility and death.

Experiments were now made on rabbits and poultry, to prove that they might absorb this gas for some time, and yet live and grow fat. These experiments were satisfactory, and after death it was quite possible to ignite the bodies, and this once done, the charred surface acted as a wick, the fat melted and burned, and the heat became intense. Water sprinkled on the body in this state caused an apparent increase in the combustion, a phenomenon noted in the case of human bodies.

Dr. Allen T. Reed describes a case of

**Abscess of the Spleen.**

The literature on this subject is, the author says, scanty, and the number of reported cases small. Pyæmia, malaria, and traumatism are possible causes.

A married man, thirty years old, had been treated for at least two months for pneumonia, and when seen by the author had a pulse of 120, temperature 103°, accelerated respiration, and clammy skin.

"He had had cold, and sweating spells, loss of appetite, occasional attacks of diarrhœa, dry hacking cough and enlargement in the left hypochondrium."

Previous to being taken sick he had been chopping with an axe for two or three weeks in such a way that the axe handle occasionally struck him in the side.

One evening he was suddenly seized by chill, high fever, cough, hectic flush, and had for several nights before this had pain in the left side. The case was then diagnosed as pneumonia, and after being treated for some weeks for this, was seen by the author who diagnosed splenic abscess, put him on general supporting treatment, to prepare him for an operation which the family postponed on seeing the good effect of systemic treatment. The abscess ruptured and a post mortem confirmed the diagnosis. The author includes in his paper a plea for greater attention being paid to physical diagnosis in medical colleges, and a hope that the laity may become educated to allow post mortems more frequently when they are desired.

Dr. Randolph Winslow read before the Clinical Society of Maryland a

**Report of Two Surgical Cases.**

The first was a successful gastrostomy and was interesting from the fact that the patient was a child three years of age, and that at one time the temperature before operation is reported as low as 90°, and 93° for a longer time.

The other case was a suturing of the intestines for perforation by a gunshot. It was followed by secondary ligation (for aneurism?) of the deep circumflex iliac, and by incision to empty an abscess in the iliac fossa.

In the subsequent discussion one or two members thought that in cases of gunshot of small calibre they would rather wait until the effects of perforation became manifest before doing a laparotomy, hoping that a small perforation, if it occurred, would close spontaneously. Other members thought it much

safer to open at once, and leave nothing to chance.

This number also contains a paper by Drs. Roland G. Curtin and Edward W. Watson on Influenza, which appeared in THE MEDICAL AND SURGICAL REPORTER of April 7th, also a paper from the *St. Louis Medical and Surgical Journal*, in which Dr. Homer M. Thomas advocates galvano-cautery as the most satisfactory treatment for pharyngomycosis, and from the *Pacific Medical Journal* an article by Dr. P. M. White on

**Sponge Grafting.**

In treating chronic ulcers, particularly varicose, and syphilitic ones the author is in the habit of making small incisions in the edges, provided these are indurated, then cutting a thin, accurately-fitting piece from a fine silk sponge, saturating it with any antiseptic solution, and pressing it neatly into the ulcer. This is now kept in place by small adhesive strips, then covered by one layer of cheese-cloth, and over this the usual cotton and roller. The adhesive strips and sponge are left in place; the sponge is moistened daily with any antiseptic except bi-chloride; the superficial dressings are changed daily.

It is only necessary to renew the sponge graft in cases of persistent indolence, and sanious pus. The final result is usually free granulations which adhere to the sponge, cause its absorption, and finally healing—*the author claims without a cicatrix.*

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Essential Paroxysmal Tachycardia.

Joseph Eichberg (*Cincinnati Lancet-Clinic*), in speaking of this affection, calls attention to the following points:

1. The affection is paroxysmal. The most careful examination fails to discover any cardiac derangement in these cases. Exertion does not cause an attack.

2. The earliest age at which a case has occurred was the ninth year.

3. Sex does not influence the disease in any way.

4. There may be slight rise in temperature during an attack, though it is unusual.

5. Auscultation, during an attack, shows that the heart is regular, though very frequent.

6. The main feature of the heart sounds is the resumption of the fœtal character.

7. The pupils are perfectly normal and active during an attack, showing absence of irritation of the cervical sympathetic.

8. The attacks occur without premonition or excitiug cause, often during sleep.

9. The attack reaches it maximum immediately The cessation is equally sudden.

10. The disease is a serious one, though seldom fatal. It is impossible to foresee a fatal termination in any case.

11. Some persons suffer for many years from these attacks. In severe cases it certainly tends to shorten life.

12. The secondary results of these attacks are very important. There is disturbance of the respiration; and acute dilatation of the heart. This latter disappears with the cessation of the attack.

The most frequent cause is mental and physical overwork. In pathology, is primarily a neurosis. Of medicinal agents, bromides and morphia in small doses, with proper rest, do most good. Digitalis is useless. No time should be wasted in trying the cardiac tonics. A rigid regulation of the mode of life is imperative. Tobacco must be abandoned.

### Convulsions in Young Children.

M. Simon (*Gazette des Hopitaux*), in a clinical lecture on this subject, remarks that the following indications should be followed:

1. Empty the digestive canal. Very many cases of convulsions are due to some condition of indigestion. For this purpose give a large enema and dose of some laxative, as castor oil, epsom salts, etc.

2. Calm the nervous system. For this he recommends a mixture of chloral, musk and water.

3. Active treatment of the skin, as by hot baths, mustard baths, or sinapisms.

4. The treatment of the case after the attack, so as to regulate the health and prevent a recurrence. This is mainly a question of the treatment of the digestive organs. Sometimes the convulsions are due to derangements of the kidneys. This requires treatment directed to these organs, such as hot air baths, proper diet, diuretics, and warm water baths.

### Essentials in a Healthful Home.

The site for a house should receive careful attention of the tenant, purchaser, or of one proposing to build. A good site may mean life and happiness, and a bad one disease, suffering and death.

1. It should be dry. Avoid, as you would death, a damp location. In a town or city carefully ascertain whether or not it is on "made ground." Avoid it. Avoid ground underlaid with clay, for it will always be damp.

2. Elevated on a hillside or gentle knoll, never in a hollow. The hillside is warmer and dryer than the hollow.

3. Not close to a swamp, slow river, milldam or land which is overflowed a portion of the year, nor in such a place that the prevailing winds will bring to the house pestilence from a milldam, etc.

4. In as good a neighborhood as possible, away from foctories, saloons, etc., and near schools and churches.

5. In a village or town build on as large a lot as possible, thus securing air and sunlight. Build back from the street, thus avoiding the dust of the dry season and the curious gaze of every passer. Secure a yard in which trees and plants will furnish both exercise and health.

6. In the country build back from the highway, giving an abundance of room for trees and shrubbery about the house. Do not select a place where your family will be isolated from all social intercourse, so necessary to the health of mind and body.

For the aspect, let the house be so placed that it will receive the most sunlight and fresh air, especially from the summer winds. Avoid, even if offered rent free, a damp, dark house, with no chance of the free air of heaven to sweep through it. If the house is only one room deep, it does well to face it to the south or southwest; but if it is two rooms deep, those on the north side never receive any sunlight, and are apt to be damp. For a double house it is the best to face to the east. Then the morning sun will warm up the front and the afternoon sun the rear of the house, and thus all the rooms will be bathed in light and warmth. The living-rooms should always be warmed by the morning sun. This hint is worth a great deal as a health matter. For when the sun cannot enter, the doctor must enter. If the cold winds from the north and west are severe in the winter, they may be broken by a cluster of evergreen trees planted on those sides. In country places a good aspect should be secured without reference to facing the house square with the street.—*Pacific Health Journal.*

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### Habitual Nose-Bleed.

Dr. Wm. Rath (*Wien. Med. Presse*) says: To the general causes of nose-bleed belong:

1. Disease of the vascular system and a change in the composition of the blood itself, such as is found in scurvy, purpura, hemorrhage, hemophilia, etc.

2. The fragility of the blood vessels following acute infectious diseases (acute exanthemata, typhoid, diphtheria), also subacute and chronic infectious diseases (malaria, pyemia, septicemia).

3. All those diseases which lead to obstruction of the circulation (valvular disease of the heart, diseases of the lungs, tumors of the mediastinum, cirrhosis of the liver, Bright's disease, amyloid degeneration of the kidneys and liver, and lastly, also the physiological process of pregnancy).

4. Vicarious menstruation, a cause now and then observed.

To the local changes in the nose causing nose-bleed belong:

1. Erosions and superficial ulcerations of the mucous membrane.

2. Varicose dilatation of the veins on the anterior portion of the nasal septum.

3. Perforating nasal ulcer.

4. Ulceration of the mucous membrane and of the bones in the course of syphilis, tuberculosis, lupus, and other destructive processes.

5. New growths—especially sarcoma and soft carcinoma.

6. A certain fragility of the mucous membrane, for which, microscopically, no cause can be assigned.

7. Trauma.—*Medical Brief.*

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### The Causes and Treatment of Migraine.

Dr. H. Gradle (*Chicago Medical Recorder*) disputes the gouty and neurotic origin of nervous sick headaches. He contends that the most frequent etiological factor in migraine is astigmatism. The degree met with in most cases that are well marked is three dioptrics. High degrees of astigmatism often cause only poor sight. Hypermetropia sometimes gives rise to it. Nasal diseases may also cause migraine. Intestinal catarrh also may be a cause.

The treatment consists in a the correction of these conditions. When properly carried out, the results are usually very good. The only drug that seems to have any permanent influence on this disorder is cannabis indica. This cures about one-third of all the cases. It must be continued for a long time, however. This drug often aborts an attack. When it does not, antipyrine usually does.

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### A Plea for Chloroform in Labor.

(W. B. Sprague, M. D., of Detroit, in *Amer. Lancet.*) The advantages of chloroform anæsthesia may be enumerated thus:

1. More rapid dilation of the cervix. The cervix and os are supplied with nerves from the cerebro spinal system, and pass readily under the influence of an anæsthetic. Even Barnes says: "Here it is often of signal service." It is especially useful from this standpoint, in cases of rigidity or spasmodic action by which the os gives unusual resistance and the result is lack of harmony of action in the different parts of the uterus.

2. It preserves the perineum by relaxing the muscles, allowing for manipulation, making it possible to deliver the head in the intervals of the pains rather than with an expulsive effort.

3. The mother often restrains the contractions to the uttermost until she is anæsthetized. The abdominal muscles are both voluntary and reflex. Labor can be greatly delayed by this restraint, and it is in these cases that labor proceeds more rapidly with than without the anæsthetic.

4. In cases of heart disease, when palpitation and dyspnea are induced, the chloroform quiets the heart and removes an element of considerable danger.

5. The exhaustion and shock of severe labor are averted, and the contractile energy of the womb is conserved, thus protecting against post-partum hemorrhage.

6. Reflex contractions of the abdominal muscles seem to be more easily induced by artificial stimulation—pressure on the perineum, etc., in the anæsthetic than in the non-anæsthetic state.

7. Most important of all, in my estimation, is the amelioration of suffering to the parturient woman. In my experience it has been rare to find a mother give birth to her child without calling upon her doctor for help and relief. These cries were often agonizing, and the lying-in chamber was to me frequently a chamber of torture before I learned that I could so easily and safely respond to them. I cannot believe that any physician can have the heart to refuse this help after giving the subject careful consideration. Lusk says: "Few practitioners give themselves the trouble to master the necessary *modus operandi* of the use of anæsthetics, to study the limitations of their usefulness, or to learn the conditions of their safe administration. It is to such that I appeal.

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### The Punishment for the Crime of Producing Abortion.

In England and Ireland the punishment is penal servitude for life, or a less term. Should the mother die, the crime becomes murder, which may be punished by death. In Scotland (says *The Lancet*), the punishment is arbitrary; in France, Spain, the German Empire, Austria, Hungary, Italy, Russia, Norway, Sweden and Denmark — in short, throughout the whole of Europe—the crime is punished by imprisonment for from six months to twenty years, or for life. In Sweden the penalty is death if the mother dies; and in Russia the mother, if a consenting party, may be exiled to Siberia; in the Dominion of Canada the penalty is imprisonment for life; in Nova Scotia, Quebec, Ontario, British Columbia, and in Prince Edward Island it varies from imprisonment for two years to for life; in New Brunswick the penalty is death; in Australia and New Zealand the punishment is very severe, ranging from two years' imprisonment to penal servitude for life; in the United States it is punished with fines ranging from $100 to $5,000, with imprisonment for long periods, and with death.—*Med. Record.*

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### A New Method of Artificial Respiration in Asphyxia Neonatorum.

Dr. J. Harvie Dew, of New York, has described a new method of artificial respiration in newborn babes, which may be summarized as follows:

Grasp the infant with the left hand, allowing the neck to rest between the thumb and forefinger, the head falling over backwards; the upper portion of the back and scapula resting in the palm of the hand, the other three fingers to be inserted in the left axilla, raising the arm upwards and outwards. Then grasp the knees (or ankles, if baby is small) with the right hand in such a way as to hold them with the right knee resting between the thumb and forefinger, the left between the fore and middle fingers. Next, depress the pelvis and lower extremities so as to allow the abdominal organs to drag the diaphragm downwards, and with the left hand gently bend the dorsal region of the spine backwards. Retain for two or three seconds, then reverse the movement, bring the head, shoulders and chest forward, closing the ribs upon each other, and at the same time bring forward the thighs, pressing them on the abdomen. Retain two or three seconds. Repeat movements.—*Canadian Practitioner.*

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### Chapped Hands and Face.

Dr. W. P. Spratling says (*Med. Rec.*) a most excellent remedy for chapped hands and face, and one that, if properly used, will cure the most painful cases in from twelve to twenty-four hours, is compounded as follows:

℞

| | |
|---|---|
| Tr. benzoin co. | min. x |
| Alcohol | ʒ ij |
| Aquæ rosæ | min. xxx |
| Glycerini | q. s. ad ʒ j. |

M. Sig.—Apply to chapped surfaces at night, after they have been washed with soap and warm water, and thoroughly dried

A second application is rarely required. This remedy is equally efficacious in the treatment of fissured, bleeding and sore lips.

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### Pruritus Vulvæ.

Dr. Ohmann Dumesnil recommends the following:

℞

| | |
|---|---|
| Hydrarg. bichlor. | gr. iss |
| Ammon chlor. | gr. ii |
| Ac. carbolici | ʒ j (more or less) |
| Glycerini | ʒ ii |
| Aq. rosæ ad | ʒ viii |

M. Ft. lot. Apply frequently.

—*Canadian Practitioner.*

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### Treatment of Anthrax in Man.

Sestina (*Lo Sperimentale*) reports a case of anthrax infection which was successfully treated by a method first adopted by Mafucci, namely, by the injection into the affected parts of rather large quantities of phenol solution. On the first day eight injections of 1 g. of a 3 per cent. solution of carbolic acid were made into the parts attacked. On the second day three injections of a 2 per cent. solution, and on the third day two more injections of 3 per cent. solution were made into the freshly œdematous parts. The lesions were covered with sublimate dressings, and phenate of quinine was given internally. Notwithstanding the large amount of quinine taken, there was at no time any sign of carbolic acid poisoning. One more interesting point about the case is the bacteriological investigations which showed that the anthrax bacilli did not get into the general circulation, but remained confined to the parts immediately surrounding the original point of infection.—*British Medical Journal.*

## SURGERY.

### Treatment of Puerperal Mastitis.

Dr. J. W. Russey, of Chattanooga, believes compression of more general utility than any simple measure, both prophylactic and curative. To be efficient for the former purpose, it must be used early after labor. The chest binder of Dr. Guiterras, is a most satisfactory means of applying pressure. If abscess forms, pus should be evacuated early and perfectly. Washing the abscess cavity is preferable to drainage tubes. If drainage is necessary, horse hair is to be preferred to rubber tubing. Great care should be taken in selecting point for incision, if circumstances admit, on account of scar in cosmetic point of view.—*Tri-State Medic. Soc. Trans.*

### The Parasite of Cancer.

On several occasions we have called attention to the investigations of Professor Adamkiewicz, of Vienna, since they promised to throw more light on the obscure etiology of carcinoma. In his latest article, which is published in the *Wiener Mediziniche Presse*, the author formulates the results of these investigations as follows: "The true and characteristic element of cancer is a coccidium. From it originate spores (larvæ), which in turn develop into coccidia and amœbæ. Metastases are produced by migration of the larvæ, coccidia and amœbæ to different parts of the body. The development of larvæ takes place within the epithelial and endothelial cells of the diseased area. The parasite, when developed, lives outside the cell and forms an integral portion of the cancerous tumor. It destroys the epithelia, but never causes them to proliferate, and it seems probable, therefore, that what appear to be epithelial proliferations are frequently colonies of coccidia and amœbæ." Adamkiewicz calls this parasite the coccidium sarcolytus, and considers it identical with the epithelial cell of cancer. Korotneff, who has followed a similar line of investigation, reaches essentially the same results. He goes even further and gives a minute description of the cancer parasite and its mode of development. Viewed with his eyes this formidable animal, when fully formed, is a gregarine, having a bulbous anterior end and terminating posteriorly in a sort of tail. It is rarely, however, that the larvæ develop into gregarines; usually they grow into a coccidium or amoeba.

Whatever practical value be attached to these observations they are, at any rate, strikingly original and deserving of careful consideration. Looked at from another point of view, they illustrate exceedingly well the contradictory character of the evidence afforded by microscopical research in some diseases. As seen by one observer, the tissues of a cancerous neoplasm consist of proliferating epithelial cells, while to another, equally careful, these same cells assume the appearance of a destructive parasite. The nuclei of the cell in the one case become the larvæ of the coccidium in the other. How can these differences be explained? There certainly seems an element of optical delusion involved in the question.—*Internat. Jour. of Surgery.*

### Mode of Controlling the Circulation through the Abdominal Aorta.

As patient lies on his back, the assistant, facing patient's feet, stands on the left side of the table, in a line with patient's umbilicus. He then places his closed right hand upon the patient's abdomen a little to the left of the middle line, the knuckles of index finger just touching upper border of the umbilicus, so that the whole shut hand will embrace about three inches of the distal extremity of the aorta above its bifurcation. Then, standing upon his left foot, his right foot crossing his left and resting upon the toes of the right, —an attitude commonly assumed by public speakers,—he leans upon his right hand, and thereby exercises the necessary amount of pressure. With the index finger of the assistant's left hand the weight necessary for the purpose can easily be estimated by the effect produced upon the flow of blood through the common femoral at the brim of the pelvis. Whenever the flow of blood through the femorals is absolutely arrested the abdominal aorta is sufficiently controlled, and no further weight should be applied.—*Annals of Surgery.*

### Thyroid Extract in Myxœdema.

Dr. F. C. Shattuck, of Boston, has treated four cases by thyroid extract, three of these being undoubtedly cases of true myxœdema, which the author believes can be added to the rapidly-lengthening list of cures by this treatment. The other case did not improve, the diagnosis, however, not being certain. Dr. Shattuck calls attention to the fact that in this, as in other diseases, there are differences of degree, total inactivity or loss of the gland being one thing, partial inactivity or loss another. Anginoid attacks are the most important untoward symptom likely to be encountered. It seems probable that the use of the remedy must be persisted in through life, and that larger doses will be required during the cold than during the hot weather. The initial dose, 1 grain (0.065 gramme), was cautiously increased according to the case.—*Boston Med. and Surg. Jour.*

## PATHOLOGY.

### The Form of Peritonitis.

Dr. Roswell Park, of Buffalo (*Medical Age*), goes very fully into the classification of peritonitis. The first method of classification he discusses is the clinical, and divides the disease as follows:

1. The Idiopathic. This form of peritonitis has been long accepted by standard authors; but the writer does not think that any such form exists. In his opinion there is no such a condition as idiopathic peritonitis. There is some disturbing condition, such as rheumatism, malaria, etc.

2. The Consecutive Form. This is the form where inflammation extends to the peritoneum from some other organ or tissue. This happens more frequently from the hollow than the solid viscera.

3 The Perforative Form. Peritonitis frequently follows the escape of the excretory or secretory material of some of the abdominal organs into the peritoneal cavity. This is usually a very fatal form of peritonitis.

4. The Traumatic Form. This includes all forms due to injury, whether the peritoneum be perforated or not. This form may be due to contusions or penetrating wounds.

5. The Chronic Peritonitis. This form is often due to Bright's disease. It has nothing in common with the acute form. It is most likely due to the constant irritation of some toxic irritant. The peritoneum is usually much thickened and opaque.

6. Tubercular Peritonitis. This form may be primary or secondary. Slow forms are not unlike that just mentioned above, with the addition of the nodular appearance of tubercle.

7. Malignant Peritonitis. Less than one-half are primary, the majority are secondary. Miliary carcinoma may be primary or secondary. Generally the symptoms are mild.

8. So-called Latent Form of Peritonitis. There are fatal cases in which pus or other evidences of diffuse or local peritonitis are found, but in which during life such was not suspected. This form is nearly always characterized by the presence of pus.

9. The So-called Fœtal and Uterine Forms. This form may arise from stenosis of the fœtal intestines, as shown by Virchow. An inflammatory form has also been noticed to occur shortly after birth. This is often consecutive to disease of the umbilicus.

The second method of classifying peritonitis is known as the anatomical. This is very simple:

1. There is the general or diffuse form.

2. The circumscribed form may result from injuries. It generally occurs about the cæcum. A rare form is found in the cavity of the lesser omentum, and is usually due to disease of the pancreas.

The third method of classification is the pathological:

1. The aseptic form, usually local, and characterized by hemorrhages or fibrinous effusions, with adhesive tendency.

2. The infectious forms, as staphylococcus, streptococcus, colon infection, septic purulency, putrid from perforation.

3. Specific forms, such as tubercular, gonorrhœal, actinomycotic. Opinions are yet divided regarding a gonorrhœal infection, though held by some good writers to be the case. The colon bacillus is now known to be the cause of peritonitis. It has been shown that the colon bacillus may escape from its usual habitat, and give rise to intense inflammation and very fatal results. The putrid form occurs most frequently after operation for perforation. The exudation is very infectious and foul smelling.—*Dominion Medical Monthly.*

### Parasitic Theories of the Origin of Carcinoma.

Dr. James P. Warbasse, of Brooklyn (in *Brooklyn Med. Journal*), discusses the parasitic origin of carcinoma. He reviews the works of pathologists who have studied this question. He calls attention to the fact, that observers of high repute, by the same methods of study, have reached contrary conclusions. Many good observers regard the so-called parasites as modified cells. The author, however, has found bacteria in carcinoma. While this is true, he holds that there is no foundation for the opinion that parasites are the cause of carcinoma. No bacterium of constant characters is always found in carcinoma. Thus the first condition of a bacterial theory is wanting. No proof has yet been advanced to show that any germs found in a carcinoma can be isolated and then reproduce the growth in another and suitable soil. There are other reasons against the parasitic theory. Carcinomata are related through the endotheliomata and peritheliomata to sarcomata; and through the adeno-carcinomata, to benign adenomata.

Then again, on etiological grounds, we have chemical and mechanical irritants as evident causes of all tumors. So, too, sarcoma or carcinoma may develop in scar tissue. From chronic inflammation of mucous membrane may come polypi, ademonata, or carcinomata. If we contend for a parasitic origin for carcinoma, we must seek for a similar origin to other malignant and benign growths.

The most plausible parasitic theory is that of the sporozoa. But this does not meet the case. The advocates of this theory are met by equally capable observers who contend that what has been called sporozoa are only endogenous cell constituents. Thus the theory of Adamkiewicz is unnatural and illogical, while the theories of Cohnheim, Virchow, Thiersch and Klebs, based on a cellular theory, meet the phenomena best.

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### On Meat Diet for Gout.

From time immemorial excessive meat eating has been considered the chief cause of gout. As medical experience corroborates this view, until quite recently gouty subjects were advised to reduce their consumption of meat to the smallest possible quantity; but a few years ago Dr. Emil Pfeiffer advocated the contrary system, and based his conclusions on the quantity of uric acid observed in the case of five healthy and six gouty persons subjected to the particular diet prescribed by him. According to Pfeiffer, this diet consisted chiefly of albuminous substances, such as meat and eggs, and also of fat and green vegetables, while carbohydrates, more especially starch and sugar, were scrupulously avoided; and analysis proved that the secretion of urea and uric acid was increased and the fluids of the body rendered as alkaline as possible. Pfeiffer concluded from the results of the analyses in these eleven cases that healthy individuals excrete more uric acid than gouty patients; but all his subsequent investigations, as well as about two hundred

determinations of the uric acid excreted by one of Mordhorst's patients, gave a contrary result. (The uric acid was determined according to Heintz's method.) As a matter of fact, sufferers from gout extrete, on an average, more uric acid than healthy persons, and a strictly meat diet, so far from rendering the fluids circulating in the body more alkaline, has the opposite effect. It is a well-known fact that the power possessed by a fluid for dissolving uric acid depends upon its alkalinity. Unfortunately, although we can readily render the urine alkaline, it is extremely difficult to render those tissues which are predisposed to the deposition of uric acid deposits neutral, much less alkaline. The urine of a puppy receiving a daily ration of a couple of rolls and about eight ounces of milk is invariably slightly alkaline, whereas that of a similar puppy, only receiving meat as well as milk, never gives anything but a strong acid reaction.—*Provincial Med Jour.*

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**The Relation of Syphilis to General Paresis.**

Dr. Frederick Peterson states that his study of this subject leads him to submit the following brief conclusions:

1. A history of syphilis is found in sixty or seventy per cent. of cases of general paralysis of the insane.

2. The fact must not be lost sight of that in thirty to forty per cent. of these cases no history of syphilis, congenital or acquired, is to be found.

3. Antecedent syphilis is seven to ten times more frequent in general paralysis than in other forms of insanity.

4. Syphilis is therefore to be looked upon as a frequent but not a constant factor in its production.

5. But paralytic dementia is not a form of specific disease, not a late syphilitic manifestation, nor is it a form of degeneration dedepending upon syphilitic poison for its origin.

6. The relation of syphilis to general paresis lies in the facts that it is a widespread disorder in all communities; that it weakens the constitution and vitiates the blood in many whom it infects, and that the system is thus prepared in many cases for the direct operation of the final etiological factors of general paresis, viz.: alcoholism, excessive venery, heredity, and mental overstrain and excitement.—*Toledo Med. Compend.*

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**The Local Lesion of Scarlet Fever.**

Dr. W. Dowson, in a paper on this subject, submits the following propositions, viz.: That (1) tonsillitis is invariably present from the very first in scarlet fever; (2) it is the first sign apparent, both to the patient and the observer; (3) it recurs in relapses; (4) its severity is directly proportional to the severity of the other associated features of the disease; (5) this difference in severity of the throat affection and its relation to the other marks of the disease are recognized as affording a basis, to a great extent, for the clinical classification of the cases of this disease; (6) it is absent just in those cases where there is probability that the local infection takes place at an unusual situation, as in surgical and puerperal scarlet fever; (7) it leaves in the tonsil a permanent lesion, which can be observed long afterward; (8) people who have normal tonsils have not suffered from scarlet fever; (9) people who have gone through an attack of scarlet fever have not normal tonsils; (10) the immaturity of the tonsils at birth, their development in early childhood, the onset and establishment of puberty acting by way of the tonsils, and the atrophied condition of these organs after the age of 30, control, to an important extent, the incidence of this disease. He claims, in fine, that, as in diphtheria, the throat condition and cervical bubo of scarlet fever are the analogues of the chancre and inguinal bubo of syphilis, or of the intestinal ulcers and enlarged mesenteric glands of enteric fever.—*Medical Chronicle.*

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**Congenital Absence of Lung.**

Professor Tikhomiroff, of Kiev, exhibited a preparation of the right lung and the heart of a woman 24 years of age. There was a congenital absence of the left lung. The case was of interest from the practical as well as theoretical point of view. (*a*) The normal nutrition and development of the body had not been impaired. (*b*) The pulmonary apparatus is, in the first periods of embryonic life, single; for in the case described there was no indication of the left bronchus, and the pulmonary artery had but a single trunk.—Russian correspondence of *La Medecine Moderne.*

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## ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM APRIL 21, 1894, to APRIL 28, 1894.

Major Charles K. Winne, on being relieved by Major Gibson, is ordered to duty at Fort McHenry, Maryland, relieving Captain CharlesB. Ewing, Assistant Surgeon.

Captain Ewing, on being relieved by Major Winne, will report for duty at Jefferson Barracks, Missouri.

Major Valery Havard, Surgeon, is relieved from duty at Fort D. A. Russell, Wyoming, and ordered to David's Island, N. Y., for duty at that depot; relieving Major Joseph R. Gibson, Surgeon.

Major Gibson, on being relieved by Major Havard, is ordered to Fort Snelling, Minn., for duty at that station, relieving Major Chas. K. Winne, Surgeon.

Captain William L. Kneedler, Assistant Surgeon, will, in addition to his present duties as Post Surgeon, Fort Mason, Cal., perform that of Attending Surgeon, San Francisco, California, until further orders.

Leave of absence for one month, to take effect on or about April 24, 1894, is granted Captain James D. Glennan, Assistant Surgeon.

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# ORIGINAL ARTICLES.

## THE MARRIAGE OF SYPHILITICS.

WILLIAM G. PORTER, M. D.,* Philadelphia.

Mr. President and Fellows of the College of Physicians: Perhaps no more important or interesting question could have been submitted for our discussion to-night than that of the Marriage of Syphilitics, and I must confess that I approach its consideration with an amount of diffidence which I would not have supposed to be possible some years ago. It would be very easy to dispose of the whole question by giving to our patients who have been afflicted with syphilis and who are contemplating matrimony the celebrated advice of Mr. Punch to those about to be married, "*Don't!*"

But in regard to this question we have a solemn duty to perform; on our decision may depend the future happiness and health, not only of our patient, but that of an innocent and virtuous woman and of children yet unborn.

The subject is so large in all its bearings that it will be simply impossible for me to more than outline some of its more salient points to-night. In approaching the subject we must consider first *our patient.*

If we forbid him to marry, and he takes our advice, we condemn him to perpetual celibacy—we rob him of all the joys of matrimony, of possible paternity.

If we are right in our judgment we have nothing with which to reproach ourselves.

But if we have acted inadvisedly; if he is really incapable of transmitting the disease to others; if he is capable of procreating healthy children; if he has a long life of health and usefulness before him; if, in other words he is cured—we have done him a lasting injury, we have blighted his life, we have robbed the State of a citizen who would in all probability have been more useful married than single.

On the other hand, if we advise our patient, who is or has been syphilitic, that he can safely marry, and he follows our advice and infects his wife or procreates syphilitic children, we have not only injured him, but inflicted irreparable injury on an innocent wife and helpless children.

Now, gentlemen, are there any rules which may guide us in the determination of this most important question? Of course, in an assemblage of physicians like this it would be entirely out of place for me to address you as I would a class of students. You are all more or less familiar with the disease. Many of you are experts in its detection and treatment, both as specialists and as general practitioners. In the limited time at our disposal it would be impossible to offer the proofs of all the statements I shall make; I must, therefore, endeavor to limit myself to propositions which, I think, we can all endorse, and see if we can reasonably make any deductions from them.

In the first place, then, I would say that syphilis may be classified for our purpose into three varieties, viz., the benignant, the moderate, the malignant.

I suppose that it has occurred to all of us *occasionally* to have seen cases of primary syphilis which have been followed by an exceedingly moderate amount of secondary symptoms, and then, almost without treatment, by perfect recovery and the

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absence of further manifestations; to these I would apply the name of benignant.

By moderate syphilis I mean those ordinary cases in which the disease runs through its various stages without severe symptoms—perfectly responsive to treatment, generally controlled by it, but which it may take many months or perhaps some years to cure.

By malignant syphilis I mean those cases which are very severe from the start, in which the earliest secondary symptom may be a rupia with a profound cachexia, or immediately on the disappearance of the chancre, or even sometimes before it has disappeared, the nervous system of the patient may be profoundly affected.

Recognizing these three varieties, my next proposition is that all three forms are generally curable: the first exhausting itself, the latter two requiring the treatment of the *skillful* physician to overcome them. Gentlemen, I say *skillful* physician, for there is no disease which responds more rapidly to proper treatment or shows worse results when improperly treated than syphilis.

We know that syphilis is curable from the fact that many patients remain indefinitely without a recurrence of symptoms, and more than all that, they not infrequently contract it a second time. But up to the present time no means has been discovered by which we can say absolutely to any individual patient, "You are cured; you will never have a return of this disease unless you contract it again." Because of this many writers on syphilis claim that as we can never say absolutely that a patient is cured, we have no moral right to advise him to take the chances of matrimony; that we can never tell, even after the lapse of years, when a relapse may occur, and the patient, who has supposed himself to be cured, may transmit to his posterity this terrible disease. Now, it seems to me if there is one thing established in medicine, it is the power of medical treatment over the manifestations of syphilis. Who among you has not seen symptoms disappear under treatment almost as if by magic, cases apparently the most hopeless restored to health, and yet it happens to all of us occasionally to see cases which, in spite of systematic and long-continued treatment, persistently relapse. They are not really ill; they go about attending to business and the affairs of life as usual; and yet we know and they know that they are not well; the slightest indiscretion is sure to produce a temporary relapse, and so it goes on for years and years. I think that all of us who have been in practice for twenty-five years or more must recognize the fact that we do not see nearly as many severe cases of syphilis as we formerly did, and yet if we consider the numberless pathological conditions which it most assuredly causes, we must admit that it is still a most serious affection, and one which results much more frequently in death than is generally supposed.

Now, under what, if any, circumstances, are we justified in informing a patient who has suffered from this disease that it will be safe for him to marry?

In the first place, marriage should be absolutely forbidden to any patient who presents at the time he consults us any of the symptoms of syphilis—primary, secondary, or tertiary. Let me quote here from the master of this subject—Fournier:

"What then is marriage in its completeness, gentlemen? Marriage is not only an affair of sentiment, of passion, of convenience, and of interest; to consider it from a standpoint more practical and at the same time more elevated. Marriage is an association freely entered into, where each contracting party is pledged to bring in good faith a share of health and physical vigor, with the view of co-operating, on the one hand, for the material prosperity of the family, and, on the other hand, for the raising of children, the supreme and sacred end of every union.

"Now what, in this case, I ask you, will be the share contributed to the partnership by a husband syphilitic, and not cured of his syphilis? His share will be that of a health compromised, hypothecated, burdened with a debt hereafter due the pox, that pitiless creditor."

"On account of the pox it may happen that this man may experience one day or another such and such serious affections which will ruin his health, such and such an infirmity which will render him incapable of work, incapable of earning his daily bread; and then what will become of the family, of which this man is the recognized support? what will become of his wife? what will become of his children?

"On account of the pox also this man may die. What may happen, he being

dead, to his wife and to these children?

"Is it admissible, then, that a man should think of creating for himself a family when he is liable to fail this family? Is it admissible? Is it right? Is it mortal that a man should dream of having a wife and children when he offers the possible prospect of widowhood to this wife, of orphanage to these children, of poverty to this family? No, a hundred times No!

"Also, and I do not hesitate to say it, the man who is syphilitic, and not cured of his syphilis, fears not nevertheless to append his signature to the marriage contract, commits at this moment a base act, an act immoral and corrupt, an act which good people will be unanimous in condemning."

In the second place, marriage should be absolutely forbidden to all syphilitic patients who have not been subjected to a most thorough, complete, and prolonged treatment.

And finally, in the third place, before sanctioning the marriage of a syphilitic, the requirement of a sufficient treatment having been fulfilled, the physician should be satisfied that he is in perfect health, and that he has had no symptoms, even suspicions, of syphilis for a period of at least two years.

Under these circumstances, and with these limitations, I have no hesitation in telling patients that I think they are reasonably safe in marrying, and I have never yet had reason to regret the advice which I have given.

## HYDROPHOBIA.

HIRAM CORSON, M. D., Plymouth Meeting, Pa.

[Continued from Page 672.]

### CASES.

Case reported by Dr. John W. Green, of New York.—When Dr. Green had heard his statement and that he had been bitten by a dog, he sent for his family physician. They met late at night and advised a course of treatment; but he would do nothing, and said, "There is no hope for me. I must die." The nervous disturbance increased; he could not sleep; was restless; asked them to stop him, so that he could not hurt anyone. At eleven o'clock next day he was attacked with a convulsion; four or five strong men seized him, threw him on the bed, face down, and from fear of injury kept him there till the spasmodic action ceased. When they loosed their hold he was dead.

Yet this case of mental terror was reported to the Committee of the American Medical Association as a case of hydrophobia.

Case 24 of the Report.—Mr. Hopkins was punishing his own dog that showed no signs of ill health or madness, and was bitten by him. Two days later he untied the dog and he went away. This frightened Mr. Hopkins and he began to read about hydrophobia and talk about it. His mind continued to be greatly occupied, but he was not attacked for nearly three months. He was then ordered Dover's Powders, 10 grains every hour; at 10 P. M. tincture of aconite was added. He died sixty-one hours from the attack.

How evident, that it was the result of brooding so long over the fear of hydrophobia.

Dr. Winthrop Sargent's Case.—I have had one case, in 1849, at Manayunk. Drs. Thomas Betten, Conroy and two others saw it. Dr. Betten said he had some experience with the disease and pronounced it a perfectly sure case. The patient had been bitten some weeks prior by a slut that had a litter of pups, with which he was meddling, which aroused her anger and caused her to bite him. After the biting she was chased away with intent to kill her, but they did not succeed, and it was not until some time after the patient died that the slut returned perfectly well and was permitted to live.

How convincing is this case that mental terror led to feelings and acts which this man had heard were attendant on hydrophobia, and the nervous system gave way to his fears.

Dr. W. L. Atlee's Case, No. 11.—Mrs. Kelly, bitten November 3d, 1838. Dr. Penypacker saw her on the 5th. Ordered wound washed with salt and water, and a salt poultice applied. Was advised to try Stoy's cure. Went through a full course after which she was quite well, until about three weeks before Dr. Atlee was called (February 9th, 1839), from which time, until then, she had not been very well. It was a pain in the arm extending to the shoulder, for the last three days. She had blistered the arm after first using a liniment on it. But she had not got relief. Dr. Atlee had been sent for.

It was evident to Dr. Atlee that both herself and her husband feared the dog bite was the cause. Indeed, the husband so declared for himself. It was then 9:30 A. M. From this time the doctor's conduct must have been to her strong confirmation of her worst fears. She had sent for him because of rheumatism, as she averred, and he writes: "I found the symptoms as above described, with the pain more acute in the joints than elsewhere, taking in the character of the local symptoms of acute rheumatism. Her countenance was anxious and her manner a little hurried." I ought to say, that on this visit he did not know that the dog had bitten her. She only complained of rheumatism, and that he prescribed for. On leaving her he told her, "To send word for him in the morning, if she was not better, or sooner, if she became worse." The next morning he saw her at 9:30 o'clock. She had spent a bad night. Soon after going to bed felt as if suffocating, with pain at precordia, etc., and after that could not sleep. Every few minutes she would start up in great distress and sense of smothering. [This increase of distress was evidently due to the doctor's expressed wish to be sent for if she got worse.] It was at this visit, Saturday morning, that Dr. Atlee learned all about the dog bite and the Stoy remedy, so Dr. Atlee adds: "After giving me this history of herself, she said 'she did not believe the disease was from the dog bite,' but her manner disclosed that she secretly believed *that* to be the cause." Dr. Atlee had gone then at 9:30 A. M. and the long story of her case had been told him by her, her husband, too, being present. So it was doubtless 10 o'clock before he left. At one o'clock he visited her again. He writes: "She received me tranquilly and expressed herself glad to see me. Her husband said 'he believed her illness came from the bite of the dog.' She said, 'No; it's rheumatism. I will soon be well of the spasms.'" At 3:30 P. M. he visited her, having his brother, Dr. John, with him. "The visit of my brother produced no unusual agitation. She seemed glad to see us and got up and offered us chairs requesting us to be seated. Called again at 8 P. M.; she was no better. On next day, the 11th, visits at 8 and 11 A. M. and at 3, 6 and 8 P. M., five visits in a day. During that day she was much engaged in prayer. Had Dr. Atlee to read parts of scripture to her, first the 52d chapter of Isaiah. Then she said, 'I am afraid of tiring you, but I would like to hear more.' Then I read eight or nine succeeding chapters, at the end of each chapter asking her if I should read more. She replied, 'You are too kind; but if you are not tired I should like you to read of the sufferings and death of our Saviour.' I then turned to Matthew and read for her. During all this time she remained perfectly tranquil and composed, although her spasms had been so violent before." Before I left she desired to know my opinion of her case. By suggestion of Dr. Atlee a clergyman was called; she talked freely with him. At this time there were four doctors. "The clergyman was engaged with her, in conversation and prayer, about half an hour. During the whole of this period she was remarkably calm and free from spasms, although her paroxysms before and immediately after were frequent and of the most violent character."—p. 277. "It would appear from this," says Dr. Atlee, "as if the exercise of the mind had some mysterious connection with the production of spasms. For as the paroxysms were entirely suspended while the mind was engaged in this all-absorbing question, and as they reoccurred as soon as the mind was not thus exercised, it would indicate almost as close a relation as cause and effect."

[The members of the profession will observe the correspondence between this circumstance of this case, and a distinguishing feature of chorea, viz: the act of volition being necessary to the convulsive movement. For *volition* substitute nervous system.—H. C.]

The case went on. Spasms, no food, no drink, much medicine, quiet rational spells. At no time was it needful to tie her or restrain her. No disposition to bite, no barking like a dog, though she was somewhat hoarse. She sat in a chair during the whole course of this disease fearing suffocation if she should lie on the bed. She died at 11.30 A. M. on the 13th. Four days after the attack began, about as it appears from the history of numerous cases, as life can be maintained (I suppose) under such a fierce strain of the nervous system. Spasms, no food, no water, no rest in bed and much medicine.

### *Effect of a Dog's Bite.*

AFTER SUFFERING INTENSELY FOR DAYS, A MAN DIES IN TERRIBLE AGONY.

Lynn, Mass., June 8.—John Anderson, a Swede, three weeks ago was bitten on the hip by a dog. The wound was not cauterized and Anderson was taken ill on Monday, and at once had a decided antipathy to water.

Tuesday night he began frothing at the mouth and was unable to take food. The sight of strangers caused him great fright. About midnight he began barking and snarling like a dog and raved in delirium. In his struggles he bit at his friends and tore the bed clothing to ribbons with his teeth. He gnawed the footboard and posts of the bed, his teeth sinking into the hard wood. He died in the greatest agony. Consulting physicians pronounced death due to the effect of fright and its subsequent action on the heart.

### *Death from a Dog Bite.*

A YOUTH FALLS A VICTIM TO HYDROPHOBIA OR MENTAL FEAR.

Four or five weeks ago Charles Hensey, a fourteen year old boy, who lived with his parents at No. 39 North 37th street, was bitten by a Dalmatian coach dog he was romping with. The dog had been taught a number of tricks, one of which was to jump from the ground and catch objects from the hand. The boy was engaged in this sport, when one of the dog's teeth accidently pierced a finger of his left hand. The wound was cauterized by a physician, and, as it healed rapidly, the bite was forgotten until Monday last, when the lad began to complain of severe shooting pains in his left arm and shoulder. The boy was employed by Mr. Taggert, a sewing machine agent at 3733 Market street, who, when young Hensey complained of the pains, sent him to Dr. Hopper for treatment. The relatives of the lad, however, objected to Dr. Hopper and sent him to an herb doctor at Bridgeport. This individual laid his hands on the boy and, giving him a cup of tea, said the prespiration that would ensue would drive the poison from the system. No prespiration followed the dose and the lad's relatives, being convinced that there was no poison in his system paid no further attention to his complaints until Wednesday, when he fell in violent convulsions. During the spasms which followed in rapid succession the sufferer foamed at the mouth and displayed all the usual symptoms of rabies. The convulsions were so violent on Wednesday that it required the united exertions of six men to keep him in bed. Towards evening he became quieter and at seven o'clock died. The boy is said to have been excessively nervous and sensitive and the attending physicians are of the opinion that he brought on the convulsions by brooding on the subject of hydrophobia.

### *Died of Hydrophobia.*

Frederick Miller, thirty-four years of age and married, residing in the rear of 903 South 5th street, died at eleven o'clock Saturday night, at the Second District police station, of the most violent symptoms of hydrophobia. Strangely enough he was bitten four months ago by a small dog owned by Robert Clark, a lumber dealer, at Fifth street and Washington avenue. The dog had bitten several persons and its owner had consented to its slaughter. Miller, who volunteered to be its executioner, picked the cur up in his arms, but it squirmed and bit him severely on the lip. The dog was at once dispatched. Miller worried constantly and talked of nothing but hydrophobia, until he showed signs of being out of his mind. He became so violent on Saturday last that he had to be locked up in a station house cell for security.

### *Hydrophobia Again.*

A YOUNG MAN'S WRETCHED DEATH.

Coroner Janney this morning held an inquest in the case of Frederick Miller, 18 years of age, who residedin the rear of No.

3517 Warren street. About three months ago the deceased was bitten by a small dog, which he had killed three days afterwards. Notwithstanding that he had the wound cauterized he was in constant fear of being effected by hydrophobia. About a week ago symptoms appeared which, although not strictly hydrophobia, were alarming enough to call a physician. Deceased complained of dryness in the throat, and evinced a repugnance for liquids. On Friday the deceased was affected with convulsions and on Saturday he underwent the horrible contortions. Once or twice he nearly succeeded in biting his mother, who was trying to calm him. In the latter part of Saturday afternoon his mother was compelled to have him taken to the Second District station house, where he died on Sunday morning. The attending physician testified that the deceased's death resulted more from fear of being affected with hydrophobia than from the actual presence of the disease, and that his death was caused by exhaustion; the result of acute mania, and the jury gave a verdict accordingly.

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### *Died of Hydrophobia.*

A CASE IN WHICH THE ACTUAL DISEASE WAS STUDIED TO ITS FATAL END.

Jersey City, N. J., December 5. One of the most interesting cases in the pathology of hydrophobia occurred here Saturday, and resulted in the death of Edward Coleman, of 269 Monmouth street this city, yesterday. The boy, a bright lad of six years, was bitten by a terrier belonging to a neighbor on October 22nd last. The dog bit Edward about the head and face in the most horrible manner. The boy was rescued and carried to a physician. Ten stitches were required for the wound in the face.

As it was not believed the dog was mad, the wounds were not cauterized. The reason for this was the terrier had suffered amputation of his tail, and it was thought the pain from the operation had made him vicious, so that when the boy called to him the animal was excited. The dog, it was afterward found, had bitten a cat and two chickens, all of them dying since from the effects. The dog was at once killed to prevent any further possible trouble.

The case was watched with close interest. When the boy a few days ago began to show signs of nervous affection, his parents at once concluded to take him to the Pasteur Institute in New York city. When Edward was presented to Dr. Gibier, in charge of the Institute, an experiment was made by offering the boy some water to drink. A light spasm of the throat was apparent and on repeating the experiment the patient showed plainly the signs of hydrophobia. Dr. Gibier at once decided that there was no doubt of the case, and also that the virus had become so firmly seated in the system that inoculation would be of no avail. He advised, it is said, only a simple treatment to quiet the patient and fortify him as much as possible against the poison. The diagnosis proved correct, and the boy died at his home yesterday with all the symptoms of hydrophobia.

One of the interesting points of the case is that Edward had never heard of hydrophobia, and could not have apprehended the dreadful results. His imagination was therefore not affected and the case is purely an instance of the active force of the rabies virus.

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### *Hydrophobia Victims.*

A WELL DEVELOPED CASE—THE PATIENT BEGS TO BE KILLED.

Saginaw, Michigan, July 31. Morey Godfreg was attacked by a strange dog, July 4th. It knocked him down and bit him in several places. A few days ago he complained of feeling unwell and remained home from work. Yesterday he went into a spasm at the sight of water and has since that time gone from one convulsion to another; his frenzied exertions to get away from his attendants at times required the united strength of three or four men to hold him. He barks and snarls like a dog and tries to grab his attendants with his teeth, and between the spasms begs his attendants to kill him. The doctors say it is a well developed case of hydrophobia.

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### *A Boy Dies of Hydrophobia.*

Wichita, Kan., July 31.—Robert Tankersky, aged 12, died yesterday of hydrophobia. Those who witnessed his death described it as horrible. For several hours the boy was in convulsions, and it was as much as four men could do to hold him in

bed. He was bitten months ago, but the wounds soon healed. Three days ago hydrophobia symptoms began to develop. Fear of water was the first noticed. Wednesday morning the boy had his first convulsions, but they were not bad and did not last long. Yesterday morning he was again attacked, and for hours he howled, snarled, and barked, apparently in awful agony, until death relieved him.

*Afraid of Dogs in Heaven.*

A HYDROPHOBIA VICTIM'S ANXIOUS QUESTIONS BEFORE HIS DEATH.

Jersey City, Dec. 6.—Mrs. Catherine Coleman, whose six year old son Edward died of hydrophobia yesterday, says the boy was conscious until the last hour before he died. He asked his mother if there were any dogs in Heaven. If so, he did not want to go there; he did not like dogs. His mother said the boy did not suffer very much. He was always thirsty and hungry during his last illness. He was afflicted with severe convulsions of the throat, which made it very difficult for him to take food.

*Has the Hydrophobia.*

HARRY BRASSINGTON GIVES HIMSELF UP TO THE POLICE.

New York, June 25.—A man who said his name was Harry Brassington walked into the police headquarters at Mt. Vernon on Tuesday afternoon last, and asked the captain in charge to tie him up "for God's sake," as he was suffering from hydrophobia, caused by a dog bite he had received several years ago. The sergeant thought at first he was fooling, until suddenly he became a raving maniac. He flew at policeman Myers and would have bitten him had the other four officers who were present not interfered.

Doctor Banning was summoned and morphine injections were given him, but without any effect. He became rational again in about an hour. An ambulance was summoned and he was conveyed to the hospital. He was taken again with a paroxysm when he arrived there. When it had passed he explained to the doctors that he had suffered from the same cause before and was perfectly conscious of the danger to those who attended to him.

He said that he had been treated by the Pasteur method in this city, and had thought himself cured until on his way home that afternoon he had felt the return of hydrophobia symptoms. At a late hour last night his death was momentarily expected. Brassington is the same man who, a few months ago, was found at Harlem Bridge, suffering from hydrophobia. He was taken to the Harlem Hospital and after being treated a few days was discharged.

# COMMUNICATIONS.

## URETHRITIS—SIMPLE AND SPECIFIC.

I. N. BLOOM, M. D., LOUISVILLE, KY.

I have recently had two or three cases which have furnished considerable food for reflection. They were all cases of urethritis. It is now a generally accepted fact among those who are supposed to know, that urethritis is divided into three classes:

1. Traumatic urethritis.
2. Urethritis simplex.
3. Urethritis specific.

A man having gonorrhœa is subjected to specific urethritis which is brought about by the specific germ—the gonococcus of Neisser,—carried from one subject to another, and by its development produces the disease. While there have been some differences of opinion in regard to the causation of gonorrhœa, the above is the most generally accepted theory. I am not prepared to dispute this, but two cases I wish to report have at least been food for reflection for me for some time, and I propose to give the cases first then draw my deductions therefrom, or leave the members of the Society to draw theirs.

The first case came under my observation about a year and a half ago. A man who had been married about ten years contracted gonorrhœa,—at least gonorrhœa was the diagnosis given by his physician.

The following are the particulars: The man had been on a spree and had indulged in one sexual intercourse away from his wife. Two or three days after this, having no symptoms of any kind, he had connection with his wife. About a day following this coitus, he noticed a slight discharge from his penis, and consulted me. The flow when I saw it was mucoid, scarcely muco-purulent in character, about the color and consistency of glycerine. Urination on the part of the patient was painless and there was little or no inflammation around the meatus. At the end of four or five days of ordinary treatment there was no discharge at all from the penis or in the urine; in the meantime, however, for one or two days the flow became more purulent in character, but principally mucoid and remained that way until probably the end of five days when it ceased altogether. He had not practiced coitus with his wife from the time he first consulted me, and she subsequently developed undoubted gonorrhœa which lasted four or five weeks, severe in character, with urethritis, vaginitis and pelvic peritonitis characterized by the usual symptoms and usual amount of severe pain. Previous to the time this man first consulted me, he had had no signs of gonorrhœa for ten years.

The other case—rather there are two of them which are practically alike, one of which I followed very closely, having had a microscopical examination of the discharge made by Dr. Vissman—occurred in a young man twenty-six years of age who came to me about a year and a half ago for a syphilitic affection which was then about two years old. About the same time he told me of a gonorrhœal discharge he had which came on at intervals; sometimes for a week or two it would remain quiet, then become varied in form from a thin gleety mucous discharge to (at times) a decidedly purulent flow. In the course of treatment for syphilis, I saw the patient quite frequently and he paid little or no attention to this discharge, in fact the urethral discharge was only mentioned occasionally and received no direct or thorough treatment The patient seemed disinclined to it, would not use injections nor internal medicines faithfully, and would not limit his desires or the gratification of them.

In June the man fell in love and began to think seriously of marriage. In the meantime three years had elapsed since the development of syphilitic manifestations, to which he had attended fairly faithfully, as a man can do by getting a month's supply of medicine and taking it regularly. His gonorrhœa, from his failure to give the treatment of it proper attention, had become chronic. About the last of July, when he consulted me as to the possibility of marriage, I told him that so far as syphilis was concerned there was no reason why he should not marry, but so long as there was the slightest discharge from the urethra, this feature would debar his union. Proper treatment was then instituted and carried out rather more earnestly by the patient. In August there was some improvement, and he was still more anxious to get married. I suggested to him the advisability of having a microscopical examination made, and he was accordingly sent to Dr. Vissman with instructions to take a sample of urethral discharge when he had not cleaned out the urethra for several hours, so that the discharge could be examined. This was done, and at my request Dr. Vissman made a very careful examination, and made the following report: That while there was possibly very little danger, a few gonococci were still present, and he did not think immediate marriage was advisable as he did not consider it safe to take the risk. We then worked even more vigorously in the matter of treatment, and by the middle of September, for a week or ten days, there had been no discharge. The treatment was continued and at the end of September there was still no flow. By the first of October almost a month had elapsed without the slightest sign of gonorrhœa; the mucous shreds had disappeared from his urine as thoroughly as they ever disappear in anyone who has had gonorrhœa within five years. By a most careful examination the faintest traces of mucous shreds could be seen in the urine, but there was not the slightest evidence of discharge from the urethra, and there was nothing to examine under the microscope. I then gave it as my opinion that there was very little danger from his marrying; he was apparently in the best of health; he had been examined repeatedly for stricture, which so often follows gonorrhœa, but nothing of this kind could be found, and there was no trace of the previous chronic gonorrhœal infection.

He married early in October and (of course) pursued the usual course in those cases. November passed, and late in December he came to me stating that his wife had been complaining, and told me the nature of her symptoms. He said that she had only been complaining for a few days. He very wisely thought an examination should be made at once, and for this purpose his wife was brought to my office. Upon examination I found that she was suffering from undoubted gonorrhœa; she had urethritis, vaginitis, and considerable pain in one side, with slight pelvic peritonitis. She has been under treatment since that time; she still has vaginitis but no urethritis, and the urine has become normal. There are still some evidences of pelvic trouble in the left side.

I cite these two cases for the following purposes: In the first place we have been taught that specific urethritis runs a certain course. It has probably not been the experience of anyone here to take a case of undoubted specific (so-called) gonorrhœa, such as was present in the first case and cure it in four or five days. I remember once of having a case where I thought I was producing a remarkable result in curing a gonorrhœal discharge in eleven days with resorcin. With that exception, I can remember no case of specific gonorrhœa that was cured inside of three to four weeks. Now, that being the case, the question is, did this man (unfortunately we did not have the secretions examined) have a specific gonorrhœa? If so, then it was cured in four or five days by remedies that have not been certain to effect a cure heretofore inside of twenty-eight days. If he did not have *specific gonorrhœa* how could he have given his wife gonorrhœa? It is fair to assume that this man has had intercourse with his wife quite a number of times since she has gotten better, and he has not developed any form of gonorrhœa.

In the second case the man had no discharge whatsoever from the urethra for several months previous to marriage, and has had none up to this time, and yet his wife developed an undoubted case of gonorrhœa so far as all symptoms are concerned, because there is no form of simple vaginitis which will result in urethritis and pelvic peritonitis. I never had this woman's secretions microscopically examined.

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## GOUT AND THE TEETH.*

HENRY BURCHARD, M. D., D. D. S.

This paper as originally written was titled "Diseases of the Teeth with which Medical Men should be Familiar." Since, then, I have seen in the *Transactions of the Pennsylvania State Dental Society* an article by Dr. Brubaker, which deals at length with the question of reflex disturbances having origin in disease of the teeth. In view of the existence of that able paper, it would be idle to attempt extensive addition.

There are two things, however, which are worthy of the respectful consideration of every physician or surgeon. By far the most common cause of trigeminal neuralgia is some disease of the teeth. This may be the exposure of hyper-sensitive dentine; an irritation or inflammation of the tooth-pulp; any degree or type of pericementitis; and retention of fragments of teeth after attempts at extraction. To these must be added encysted teeth, or those which have such malposition that eruption is deferred or impossible.

The dentist alone is familiar with the number of cases of trifacial neuralgia, spasmodic closure of the jaws, etc., which find relief through dental ministrations.

There is too much disposition among medical men to view teeth as little more than possible signs of hereditary syphilis, and the cause of gastro-intestinal disturbances in children; beyond this the majority of physicians do not concern themselves. This does not apply to specialists in ophthalmology and rhinology; they frequently consult with the dental practioner for possible sources of irritation in and about the teeth.

Dr. Brubaker quotes Galezowski, "that he always examines or has examined the teeth of his patients."

*Read before the Philadelphia County Medical Society, by invitation of the Board of Directors, April 11, 1894.

Certainly the most eminent men of the medical fraternity recognize what an important part the peripheral irritation, arising from dental diseases, plays in the causation of other and more serious maladies. Everyone is of course familiar with the work done by Dr. Miller, of Berlin, in dental bacteriology. There is another subject for consideration to which he calls attention—the number and variety of pathogenic organisms which find an ideal breeding-place in the human mouth. All the pyogenic cocci; those of septicæmia, of pneumonia, of actinomycosis, etc.

The more dental disease remains uncorrected, the more flourishing the colonies of these organisms.

Another matter, simple to be sure, but one in which eminent medical men have frequently erred—the distinction of diseases of the dental pulp and of the tooth's periosteum. The pulp of the tooth is not its tactile portion; it is rather that of special sense, the thermal; for thermal changes are about the only cause of response in the healthy pulp. The tactile function resides in the tooth's periosteum, the pericementum.

Teeth which respond to concussion, or pressure, have the pericementum, not the pulp, affected; in these cases the pericementum will be found dead, decomposing, or absent. *Vice versa,* those which respond to thermal change, as a jet of cold water thrown in the cavity, have the pulp affected. In the latter case, sedatives, warm syringings, and stopping are in order; in the former such measures would serve to increase the difficulty through retention of irritating materials; they require antiseptic washings, such as 15-volume solution of $H_2O_2$.

After marked pericemental inflammation, abscess usually supervenes. All counter-irritation in these cases should be in the mouth, localized over the gum of the affected tooth. In these cases much damage is done, even to-day, by the use of poultices.

There is a disease of the dental periosteum which has for years attracted much attention. It is known as pyorrhœa alveolaris, or better termed phagedenic pericementitis. This disease is the cause of the loss of as many, if not more, teeth than dental caries. As the name implies, it is a progressive destruction of the tooth's periosteum. Erosion of the teeth is another disorder known to dentists.

The purpose of this paper is to point out the association of these disorders with the uric acid diathesis, and their striking likeness to gouty affections.

So much confusion has arisen during the discussion of papers on this subject, all due to conflicts of definition, that two will be here premised as bases to work from. They form the reason for such opinions as are here enunciated. Stress is laid upon this matter, as it is desired to point out the probability of these dental disorders being accepted as pathognomonic of the gouty disorder. Whether gout be unquestionably present or even suspected, it is confidently believed by the writer that the dental symptoms are conclusive evidence of a condition akin to, or identical with, the gouty; that its three stages—tooth induration, altered secretion of glands, and degeneration of pericementum—are expressions which receive value as diagnostic signs in the order named, representing the earliest, the stimulative; the second, the irritative; and third, the inflammatory stages of the gouty diathesis.

The uric acid condition is one arising through faulty metabolism, causing the production and retention in the circulating fluids of an excess of uric acid; followed by changes of tissue degeneration or those arising from the presence of a constant irritant in any member of the connective-tissue group. This leaves open the all-important question of the exact origin of the waste product. According to all authors, heredity plays the important part as a predisposing cause. An ingestion of an undue amount of nitrogenous food, or the increased consumption of malt liquors or heavy wines is the exciting cause. Prominent among the attendant disorders is fermentative dyspepsia, a complexus of symptoms known as portal engorgement, cirrhosis of the kidney, and subacute or chronic inflammation, or rather irritation in any of the fibrous structures.

*For dental diseases.* Dental erosion is a progressive loss of tooth substance through a process of decalcification, a chemical solution of the lime salts of the teeth, evidently not associated with dental caries, and which the therapeutics of caries does not check. Its action is largely confined to those portions of the teeth in contact with the labial and buccal mucous membrane.

Phagedenic pericementitis is a degeneration of the retentive apparatus of the teeth which arises without mechanical violence, specific virus, or the selective action of drugs, and proceeds to its termination with or without the formation of calcic deposits and true pus (although the pus and deposits are usual associates), the process terminating with the loss of the teeth. It is unusual to preface the pathology of a disease by its clinical history, but it will be more clear in this instance. The teeth attacked are dense and hard; the variety which resist the causes of dental caries. Men and women are alike subject to it. As a rule the disease is evident only after the patient has attained an age of thirty or over. Although it does exist in some cases before that age, its occurrence is unusual.

There are two types of this pericementitis, depending upon the portion of membrane first attacked. The more common, and as some erroneously suppose, the only type, begins as a marginal gingivitis. The earliest symptom is a deepening of color and a softening of the gum tissue at the neck of the tooth. The inflammatory appearance increases, and by the time the case receives attention the close attachment of the gum to the tooth at this point is lost. Pockets are thus formed in which are found concretions, and pus is oozing or may be pressed from the pouches. This process continues; there is degeneration of the pericementum; an inflammatory degeneration, or a molecular necrosis; increased deposits of lime salts are found as the denudation of the tooth's root proceeds. The attachment of these teeth lessens particle by particle, thus adding another source of destructive irritation, undue mobility. One by one, they lose their retentive apparatus, the pericementum, and are extruded, cast off as foreign bodies. This ends the process; there is no tendency toward extension to the maxillary periosteum. At the utmost this may be destroyed at the edges of the alveolar process and we have a slight amount of molecular necrosis at that point in consequence. The deposits are usually hard and scaly, strongly adherent. In contradistinction to the ordinary salivary calculi, they are found beneath the gum, not on it.

The disease either persists or recurs despite all local therapeusis. It is this more than for any other reason that the disease has been ascribed to a constitutional cause. As for the dental erosion, we find in teeth of good structure a loss, particle by particle, of the enamel, and after this the dentine. This is in such situations that the ordinary solvent, lactic acid, produced by the action of microorganisms is in least amount. This is the essential difference between erosion and caries. The process is usually seen when one of the superior anterior teeth is attacked. Commonly a groove or grooves may be seen, caused by a loss of enamel upon the labial faces of one or more of these teeth. The amount of enamel surface (that containing the greatest amount of inorganic matter) affected is greater than that of the dentine. This is the reverse of the process of dental caries. These spaces of denudation are in such situation, and of such shape, as to exclude any cause except that arising from altered secretion of the mucous glands about the parts. Dr. E. C. Kirk, the editor of the *Dental Cosmos*, who has devoted much time to investigations as to this condition, has found an almost constant association of it with gout.

In most cases a history of heredity and acute outbreaks. If the patient had not yet been the victim of gouty disturbance he or she did become so, sooner or later. This is for disease with an incipient expression in mucous structures.

Cases are recorded of teeth in which the tissues about the necks of the teeth are intact; and yet, disassociated from any of the usual causes of pericementitis, we see evidences of a localized inflammation of the pericementum somewhere between the apex of the root and the neck of the tooth. The disease area spreads until there is a destruction of the entire pericementum and the tooth is lost. These cases may show no evidence of the formation of true pus until near the end, when microorganisms gain entrance through a loss of continuity of the tissues at the neck of the tooth.

Dr. Kirk has in his possession a lateral upon which there is a destruction of the apical half of the pericementum and much of the cementum; the remainder of the membrane was intact. In this necrotic area, and near the apex, was a deposit—a calculus evidently formed in the pericementum, for its attachment was so slight that it was lost. This prevented chemical analysis.

The deposits taken from these teeth have been analyzed. While some give the murexide reaction, certain others, with a clear history of gout, show not the slightest trace, being composed of phosphate of lime.

All local causes having been found insufficient to explain the course and phenomena of this particular disease, a constitutional disorder has been deemed a necessary condition for its existence. The persistence after removal of local causes assures us in such a position. Search has been made among general diseases for one which would produce a degeneration of articulative tissue with an accompaniment of crystalline deposits. In the practice of medicine but two such diseases are known—rhuematism and gout—including here as close associates of gout, rhuematoid arthritis and lithæmia. The pathology of rhuematism does not explain or agree with that of phagedenic pericementitis. We are thus driven by a process of exclusion to viewing gout as the predisposing cause. The question now is, Will the pathology of gout explain every stage of the dental disease?

Gout is hereditary in a large proportion of cases; not that this or any other disease, except in a few rare instances, is inherited, but regarding heredity as an expression of the transmission of a type of tissue. That women, who are not commonly the subjects of gout, are the victims of phagedenic pericementitis, is not an argument against gouty origin; for rheumatoid arthritis is the form assumed by hereditary gout in the female (Da Costa).

In the individual who has such a family history there is a predisposition to the formation and non-elimination of an excess of waste material of nitrogenous origin. It is rational to conceive this process as one of gradual growth; although decided manifestations of the morbid influence of the retention of these waste products do not assert themselves before middle life, the predisposition exists, and the disease process probably extends over a period before becoming recognized, the body at large resisting the morbific influence until the power of combating it is lost at some weak point or points, and the disease asserts itself. Its effects may be so insidious that our means of discrimination are insufficient to discover any aberration from an ordinary healthy standard. Like any other general irritating substance, it may be present in any amount; all other conditions being alike, the effects are in direct ratio of the amount. Results of the action of these pathogenic materials would be most evident in peripheral parts—that is, situations where there is a scarcity of blood vessels surrounded by fibrous tissue, the least vascular parts being the first to suffer. According to the degree of irritation, we may have any stage of vascular perversion, from a slight increase in the flow of blood to the stasis which precedes necrosis; in the celular elements, any stage from the stimulation which promotes constructive metamorphosis to the paralysis resulting in coagulation necrosis.

The most important of all questions relating to this matter is the exact mode of production of these waste products. Until it be ascertained whether this is an expression of faulty food metabolism or of an incomplete retrograde tissue metamorphosis, we are in the dark. Again, what part may be performed by the excretory organs and the oxygen-carriers of the blood. We may suspect the blood corpuscles to have a close relation, as there are splenic changes present. Apropos of this, the thyroid gland and bone-marrow should also be involved; otherwise we have grounds for the formation of further hypotheses as to the physiology of the spleen.

It is by no means clear what influence the liver has in the production of gout. One would infer from a reading of some of Lauder Brunton's works that he suspected that organ to be largely at fault. It is presumed that any body—any crystalline substance—resulting from causes similar to those producing uric oxide would have analogous action. We know that xanthin, or, as it has been called, urous oxide, does form nuclei of cystic calculi.

Inflammation of fibrous structures arising from such source are, perhaps, more common than supposed or conceded. The presence of an irritating product, such as uric acid, even in slightly increased amount, could produce widespread disorders of a not severe type, and render inexplicably obstinate many disease processes usually amenable to treatment.

For purpose of comparison as to the active diseases, general gouty condition,

and marked phagedenic pericementitis, Ebstein's theory fits best. It is a nutritive disturbance first, leading to necrosis; and urates are deposited in the necrotic area.

For the minutiæ of the dental trouble, first, the unusually hard and dense teeth, very commonly the subjects of pulp calcification. Accepting the uric acid diathesis to be a condition long existent, there will be for some period present in the circulatory fluids an excess of the irritating waste product, uric acid. From this there will be strictural alterations in peripheral parts. Stimulation of the peripheral cells of the dental pulp is followed by an increased deposit of calcic material, necessarily lessening the amount of organic matter present. The density of the dentine increases; its vital parts decrease. This may continue until scarcely any vestige of vital matter is left within the teeth. They become of the variety which resists dental caries. The cirrhotic process affects the parts about the teeth; the alveolar process increases in density; the thickness and elasticity of the pericementum decreases. In this connection it would be a matter of great interest to note the structure of the teeth in young patients who have a family history of gout.

At a period during or approaching middle life, the gouty condition being present, it will manifest itself in one of two ways, the intensity of the action depending upon the amount of irritating material present and the amount of resistance offered by different tissues. Altered secretion is regarded as a milder form of disorder than tissue change. Function, in the majority of cases, is altered before structure. The presence of waste material will cause, in peripheral glands, irritation during its elimination. There are numerous mucous glands in the labial and gingival mucous membrane. These may secrete an acid capable of acting as a decalcifying agent upon the lime salts of the teeth; this would explain the phenomena of erosion.

Function is in correspondence with structure; teeth of this type are designed for hard, vigorous usage. From their structure they are exposed to two probable sources of debility; one, that they may become through their lessening vascular supply of the nature of bodies foreign to the structures which support them; the other—it is questionable if, in civilized life, 90 per cent. of persons give their teeth sufficient use in view of this fact; for teeth of this description doing the amount of work their structure demands is out of the question. More than this, gouty patients are frequently gourmands, and indulge in food requiring little mastication.

Disuse and misuse are two prominent sources of debility in any part of the organism. The vital parts of such teeth will, therefore come to a state of agony through disuse. Their resistive power to morbific agents will be weakened. Disease attacks preferably a weak part; rather, a weak part permits the existence and growth of the causes of disease. According to the evolutionist definition of life it is questionable whether a perfectly healthy part can become the subject of disease. These organs are, therefore, in fit condition for the development of disease process, through their acquired debility.

The teeth and their attachments to the alveoli form articulations; the pericementum is the periosteum of the tooth's root, and the ligament which binds it to the bony walls enclosing it—the type of tissue for which the gouty poison seems to have selective action.

According to Ebstein, the gouty process is essentially necrotic. This is in marked gout, but there must be every stage of vascular disturbance antedating the necrosis. According to the degree of irritation will be the effects. Every medical man has seen gouty attacks, ranging from a slight metatarso-phalangeal arthritis to ths variety accompanied by excruiating pain, followed by deposits in the joint. So with the teeth, the phagedenic pericementitis may be an inflammatory degeneration or a necrosis of the fibrous—in fact, of all the articulative tissue. The waste matter is now in amount sufficient to produce structural degeneration. An early angiomatous change will be a swelling of the intima; this, in small vessels, will markedly impede, if not check the flow of blood. The tissues are starved, and to the extent of innutrition there will be either inflammatory degeneration or molecular necrosis.

For the deposits, preceding their formation, there is an acid reaction in the necrotic area; the blood having lessened alkalinity, through the presence of an ex-

cess of uric acid, a substance insoluble in acids meets the acid tissues and uric acid or urates are deposited. As before mentioned, the tests for uric acid did not always, nor frequently, demonstrate that substance to be present in the dental deposits. These, as analyzed by Dr. Kirk, are frequently found to be phosphate of lime. It is probable that a small crystal of a urate has acted as an irritating point around which the calculus has formed. The deposits at the necks of teeth, just beneath the free margin of the gum, do not resemble ordinary salivary calculus, or the deposits which are found near the apices of the teeth. Their probable origin has a close connection with the secretion of the mucous glands, which lie just within the border-line of the gum. As the disease progresses these encroach more and more into the area of necrosis, or their presence forms the continued irritation which determines the persistence of the disease.

As before stated, there are cases where we have no visible signs of pus. If the disease begins at the gum margin pus is probably always formed; the analogous phenomenon of gout is the tophic abscess. Several pathogenic cocci have been isolated, but there is absolutely no evidence that the disease has such a cause.

For a summing up. There is a dental disease for which local explanations as to cause do not suffice. George B. Wood, Niemeyer Garrod, Duckworth, and Bartholow, among medical men; Marshall, Peirce, Kirk, Jack, and others, among dentists, note the association of the disease with gout; in very many cases a clear history of heredity and acute outbreaks. Search has not been thorough in certain instances to determine whether or not obscure gout be present. Other cases show decided evidence of lithæmia. After the removal of all visible sources of local irritation the disease of the teeth either presists or recurs after some lessening of the severity of the local symptoms.

Some of the cases recorded by the dentists named are as follows: The teeth of certain individuals, with or without a definite history of gout, become susceptible to periosteal irritation, even an inflammation, and this in the absence of the usual local irritants.

The ingestion of an undue amount of nitrogenous food or heavy wines is followed by one of these attacks of pericementitis. Upon a withdrawal of these substances from the dietary, there is a disappearance of the local inflammation.

There is but one deduction from this: the disorder must be due to faulty metabolism.

We have a local inflammation, due to the formation and retention of what should be waste product; and what more is gout?

There are two elements—one a faulty metabolism; another, the organs of excretion do not functionate properly. As far as we have evidence, the latter seems to be the element which determines an attack of gout.

Faulty metabolism might, and no doubt does, cause the formation of incomplete oxidation products, and these excite disorders of a mild type in many, very many persons; but it is only when the organs of elimination have reached and passed the limit of their function that weak parts give way, and an explosive attack of gout results.

There is no reason why any member of the same group of substances might not play the irritant role; xanthin or urous oxides, uric acid or uric oxides, in excess they are both irritants. Pathological chemistry certainly gives but meagre account of the origin of both substances.

In about 75 per cent. of cases of true phagedenic pericementitis, dentists give an unfavorable prognosis, and despite all local measures of therapeusis results justify such an opinion.

This fits Ebstein's theory of gout, the process essentially necrotic. In any disease a prognosis is favorable to the extent to which cause may be removed and effects remedied. Both these objects are difficult or impossible of attainment thus far in the dental disease.

As for the question of therapeutics. A condition in which there is altered secretion, necrosis of certain connective tissues, with a consequent undue mobility of the teeth, the presence of necrotic material, and more or less of foreign bodies; added to these, the continuance of a predisposing cause which is also acting as an excitant. The indications are, of course, the removal of all the causes; a cure cannot be effected while any of them persists. All dead and foreign materials are to be removed. All bacteria to be destroyed,

and their further action made difficult or harmless. Faults of occlusion are to be remedied; loose teeth so fixed by splints that rest of the loose organs is assured. Local vascular disturbance is to be controlled. This is as far as local measures can be carried, and the daily experience of dentists demonstrates it to be insufficient.

General treatment involves the correction of the secretion of glands of the parts about the teeth. This evidently can only be accomplished by a removal of the causes which give rise to the formation of incomplete waste products.

The gastric and intestinal catarrh must be corrected; as the gastric disturbance is of the fermentative type, a lessening of the amount of carbohydrates in the dietary is quite as important as modifying the type of the nitrogenous ingesta.

Many of the cases gave evidence of the condition known as portal engorgement. Whether affection of this organ is the primary cause of the faulty metabolism, is a question of the utmost importance. The changes in fibrous structures at large, such as in the tissue beneath the bronchial and pulmonary epithelium, in the connective tissue of the kidney, etc., are not within the province of our special therapeutics. Certainly the general indication is the elimination of the retained, irritating waste product. How else does colchicum act? Many symptoms are relieved by producing an increased alkalinity of the fluids of the body. In some situations concretions are removed through the solvent action of lithium salts, but it is out of the question to hope for such a result with dental deposits. The tartrate of potassium and sodium is one of agents used for the double purpose of producing alkalinity of the circulating fluids, and as an eliminant through the *prima via*. This fact has suggested to Dr. Edward C. Kirk the advantages of replacing one of the bases of this tartrate by lithium; a lithium Rochelle salt is the result. The virtues possessed by this compound over the usual lithium salts and the officinal Rochelle salts is evident. While it performs the office of the tartrate in bringing about an increased alkalinity of the blood, there is added the uric acid solvent, lithium. It has a mildly laxative effect. Where it has been tried there has ensued a speedy amelioration of the annoying symptoms of lithæmia due to clogged excretion.

Dr. Bartholow calls attention to the value of manganese salts in the treatment of the gouty condition. This aids first in a correction of the gastric disorder, and secondly, as in the case of permanganate of potassium, increases the oxidizing function. Iron should, therefore, be doubly useful in the anæmia of the gouty diathesis. In this connection, is it not possible that certain obscure maladies, relieved through the inhalation of oxygen, may be cases of obscure gout, masked lithæmia?

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In a public address in England Lord Coleridge told an anecdote of Browning that gives an interesting glimpse of the poet's self-appreciation. Browning sent the jurist a copy of one of his later books of poems, and when he asked for an opinion of it was told frankly, "What I understand I heartily admire, but there are parts which for the life of me I can't understand." "Ah, well," replied Browning, "if a reader of your calibre understands ten per cent. of what I write, I think he ought to be satisfied.—*New York World.*

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Pain without fever, says a prominent physician, may be very severe, and may cause much suffering, but in acute attacks it is not dangerous. "If you had this amount of pain that you complain of," he said to a patient who had hastily summoned him, "in any inflammatory disease, you would be in a raging fever; if you have no fever you need never worry." Most serious illnesses are preceded by a chill. This is a symptom which should never be disregarded, and it is always safest to put a child to bed and stop its food. Warmth and dieting will be found to be the best remedy for any ordinary indisposition, while for the beginning of any serious trouble it is often the only thing that can be done until the disease declares itself.—*Good Health.*

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An Unusual Occurrence.—Mr. Hudson Rivers—"I suppose fights are of very common occurrence in your native town."

Colonel Longhorn—"Yes; there is so much fighting that when a disturbance of some kind is not taking place large crowds gather to see what is the matter.—*Texas Siftings.*

# TRANSLATIONS.

## THE SACRAL METHOD FOR EXTIRPATION OF THE UTERUS.†

Dr. Hochenegg contributes some interesting facts to medical literature on the above subject. During 1885, Kraske performed a resection of portion of the sacrum in order to facilitate extirpation of the rectum; he named this method "Sacral Rectum Extirpation." Later (1888) Hochenegg and Herzfeld decided to utilize this method in selected cases for uterine extirpation instead of performing it per vaginam or by abdominal section.

Dr. Herzfeld presented a paper on "Sacral Extirpation of the Uterus" at the Gynæcological Congress held at Breslau, May, 1893, which called forth a lively discussion, and in which the majority of German gynæcologists opposed its adoption.

Hochenegg, in this present contribution, is anxious to prove its usefulness in certain selected cases, and reports from his practice 25 cases in which the sacral method was used to extirpate carcinomatous uteri; in most of these the disease was so far advanced that extirpation *per vaginam* would have been impossible; there were four deaths due to the operation.

A collection of other reported cases found in medical literature number 98, with a total of 18 deaths, or a mortality of 18.3 per cent.

The convalescence is somewhat prolonged (6 to 8 weeks) in comparison to other methods. The points in favor of the sacral method are: That the field for operation is more accessible; any bleeding vessel can be readily and securely tied; the large blood vessels are easily isolated and tied, and the ureters avoided. Many cases which are hopeless for the vaginal method can often be radically removed by the sacral method,—for instance, such in which the bladder and intestines have become implicated, or such where isolated carcinomatous deposits could be found in the parametrium, or fibroids and ovarian tumors necessitated removal.

In a contracted pelvis or vagina in which there is a carcinomatous uterus with pyo-salpinx or ovarian abscess, the sacral method permits of greater accuracy and facility in their removal.—*Med. Neuig.*, No. 15, 1894. W.

## SYPHILIS TREATED BY INTRA-VENOUS INJECTIONS OF SUBLIMATE.

Prof. Baccelli highly recommends this form of treatment after having given it a fair trial in the clinics as well as his private practice, particularly in such cases in which the ordinary methods have produced little or no curative effects. The solution used by him contains the following:

℞ Hydrarg. Bichlor..... 1 0.
Sod. Chlor..... 3.0.
Aq. Dest... ..... 1000.0.

The skin is thoroughly disinfected, and the veins made prominent by previous bandaging, the needle of a hypodermic syringe is introduced into the selected vein and the fluid injected. The cure begins with one daily dose of one milligramme or one cubic centimetre of the 1: 1000 solution. This is increased to 2 3-4-8 mgrms.

The author gives the following reasons for the adoption of this method as an improvement on others:

1. The necessity of using the smallest dose necessary to effect the desired cure, and which is not always achieved by the hypo- and endermic methods.

2. The possibility of overcoming rapidly such symptoms due to direct blood poisoning from the syphilitic virus.

3. The prompt and general action upon the walls of the blood vessels, which is a particularly favorite seat for syphilitic changes.—*Med. Neuig.* 1894. —W.

† Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

THE Modern Pawnshop: Give the devil your time and he will lend you trouble.

## TREATMENT OF ECLAMPTIC ATTACKS IN CHILDREN.

The child should be placed in bed, the room thoroughly aired, a careful examination made with a view to finding the cause; a mixture of a teaspoonful of salt, 3 or 4 of oil to one glass of lukewarm water, used as an enema; if the mouth can be opened it is well to touch the fauces with the feather edge of a quill, and give a quickly acting purgative. Should the attack continue in its severity, the following mixture is used as the first was:

℞
Mochi..... 0.2.
Camphor..... 1.0.
Chloral Hyd..... 0.3—1.0.
Vitell..... 1.
Aq. Dest..... 150.
M. Sig. Used as an enema.

Also a mustard bath, quarter to half hour; during severe convulsions chloroform may be carefully administered; between the attacks absolute rest is indicated and the administration of the following mixture:

℞
Zinc. Ox..... 1.0.
Hydrarg.....
Valerian.....āā 0.5
M. ft. Pulv. Div. in part equal No xii. Sig. Two powders daily before meals.

—*Med. Neuigkeit.* No. 15, 1894. —W.

If thy foe be as small as a gnat, fancy him as large as an elephant.—*Ex.*

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### MEDICATED TENTS FOR CANCER OF THE UTERUS.

Dr. Ch. Jennings (*La Semaine Médicale*, No. 23, 1894) recommends the employment of a medicated tent of the following composition, in treatment of cancer of the uterus:

℞

| | | |
|---|---|---|
| Methyl Blue, Tannin.....āā | 25 | (grs. iv). |
| Powdered Opium..... ..... | 05 | (grs. ¾). |
| Olive Oil.....xv gtts | | |
| Cacao Butter.....45 | oo | (ʒj ¼). |

Sufficient for one tent. Introduce one every day into the cervical canal, keeping it in place with a tampon.

### LACTIC ACID IN TUBERCULOSIS OF THE BLADDER.

Dr. Witzach (*Hospitals-Tidende*, No. 10, 1894) speaks highly of instillation of a five per cent. solution of lactic acid in patients with tuberculosis of the bladder, especially in those cases where an operation offers but little hope of improvement, or is refused. He has employed this treatment in five cases; in three of these there was a remarkable improvement, while in the other two the action was less pronounced. In order to prevent the pain of instillation he later came to use a combination of lactic acid and cocaine—cocaine lactate—which is a syrupy fluid. Twice a week he instilled a gram—fifteen drops—of the following solution:

℞

| | | |
|---|---|---|
| Lactate Cocaine..... ...1 | o | (grains xv). |
| Lactic Acid ..... | | |
| Distilled water.....āā....5 | o | (ʒj ¼). |

### A TONIC PILL.

In the (*Revue Médicale*, March 18, 1894) the following formula is presented as a serviceable tonic pill:

℞

| | | |
|---|---|---|
| Extr. Cinchona | | |
| Extr. Kola, .....āā 5 | o | (ʒj ¼) |
| Extr. Rhubarb ..... 2 | 50 | (grs. xxxviij). |
| Extr. Nux Vomica ..... o | 50 | (grs. vijss). |
| Arsenite Iron ..... o | 20 | (grs. ij). |
| Powdered Kola Nut..... | Q. S. | |

Sufficient for one hundred pills. Two at each meal.

### ASTHMA.

Dr. R. v. Rokitanski (*Norsk Magazin for Laegevidenskaben*, No. 4, 1894) praises the following formula, in asthma:

℞

| | | |
|---|---|---|
| Chloral Hydrate..... | | |
| Iodide Potash .....āā 2 | o | (grs. xxx). |
| Water.....150 | o | (ʒivss). |
| Syrup Orange Peel ..... 20 | o | (ʒv). |

Two to five tablespoonfuls a day.

### ACUTE OR CHRONIC CORYZA.

Dr. L. Dessar (*La Semaine Médicale*, No. 23, 1894) recommends the following powder as a convenient and efficacious snuff, in acute and chronic rhinitis:

℞

| | | |
|---|---|---|
| Starch .....5 | o | (ʒj ¼) |
| Powdered Boric Acid.....3 | o | (grs. xlv). |
| Subnitrate Bismuth .....2 | o | (grs. xxx). |
| Menthol.....1 | o | (grs. xv). |
| Tannin..... | 20 | (grs. ij). |
| Muriate Cocaine..... | | |
| Aristol..... .....āā | 05 | (grs. j). |

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

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SATURDAY, MAY 19, 1894.

## EDITORIAL.

### THE GENEROUS PROFESSOR AND THE PRODIGY'S RETURN.*

In a certain city, called the City of Brotherly Love, there dwelt many wise men and those having knowledge of the things that pertain to theology, to law, to medicine and to all things wherein men are learned.

There were also many great schools wherein was taught all kinds of knowledge.

And the fame of these schools and the wisdom of the learned men was very great, insomuch that the report of them spread abroad throughout all the world.

And it came to pass that a certain physician who was held in much esteem, fell sick of a grievous malady and was gathered unto his Fathers.

And there arose great lamentation throughout the city.

Then certain of the sect of professional philanthropists who are called promoters (for this sect professes that the relief of the needy can be done in none other way than by assisting individuals, and hold themselves ever ready to be used as examples of their faith) took counsel together as to what they should do.

For they were sore distressed, crying, Woe unto us! How is the mighty fallen! And there is none to take his place.

For we have searched and, behold, there is none, no not one among all the four hundred who wear the phylacteries, who can fill the sandals of him who is departed.

And they rent their raiment and put on sack-cloth and ashes and cried aloud exceedingly.

Then there arose one among them, and spake unto them saying: Men and Brethren hearken unto me. Why sit ye here mourning. Arise now, put off your sack-cloth and clothe ye yourselves in your right minds if, peradventure, ye have any.

Know ye not that the present is a great time for professional philanthropy?

Ye say, and ye say truly, there is none among the four hundred who have the phylacteries who can fill the shoes of the departed.

But verily I say unto you there is one who dwelleth in a far country which is

* Fragment of a record exhumed from a modern tumulus.

famous for the greatness of its inhabitant's footgear, who is willing to put on these shoes if he is able.

For I say unto you he is a Prodigy.†

Now, therefore, let us send unto him and beseech him to come and dwell among us and wear these sandals, that we may no longer be bereft.

And if so be that he is not able to put them on, behold there is at hand a retreat wherein he may be fed and clothed until such time as he be grown to fit the shoes.

Thus shall we aid the needy and show forth the glory of philanthropy, that all men may know that of Faith, Hope and Charity—the greatest of these is charity, which suffereth long and is kind, and covereth a multitude of "skins."

And they all agreed together, marvelling much that one of their number could so devise, for professional philanthropists are not accounted wise or learned.

And they indited epistles to the Prodigy beseeching him to come and help them, saying, All charges will be paid at this end.

And they sent the letters safely by servants of the government.

And it came to pass when the letters were delivered unto the Prodigy, that he read them and gave heed unto them.

And he took counsel with himself saying, Lo, here is a snap! Behold, I have dwelt in this land these many days, waiting to build sandals large enough to wear in years to come and have not yet secured an estimate.

And behold, I am entreated to go hence and, in an ancient city, wear the greatest pair—for so he had been told.

Moreover, all charges are prepaid, and there is a mansion waiting wherein I may reside the while these shoes are being half-soled and heeled.

Now, therefore, I will arise and will go unto that city, I and all my family with me, that nothing may be left to show I ever lived elsewhere.

†Or Protégé. As is evident from the context the two words are used as synonyms in the original.

And he arose and did as he had said.

Now it came to pass when he arrived in the City of Brotherly Love, that great misfortunes came upon him because that the professional philanthropists, though endowed with shrewdness, had not commonsense.

For it so was that the sandals which had seemed so mighty unto them, were far too little to be worn by many men who deemed it shame to wear phylacteries.

Likewise they reckoned without cause, in that the Rulers of the chosen retreat would none of the Protégé.

Saying, Go to! This business is not yours, nor can ye meddle with it.

Thus was the Prodigy put in sore straits, for he had not wherewith to house nor clothe himself, neither had he ought to eat or drink, save what was given him.

Now there was in that city, a righteous man of profound learning, who was also a teacher in one of the great schools of the city.

And such was his wisdom and skill and his kindliness of heart, that he was greatly beloved of all that listened to him.

Likewise, his learning was set down in books, and his name was spoken as one having authority, even in the uttermost parts of the earth.

And men came from every nation to be taught by him those things which must be known in order to heal the sick and minister to the afflicted.

And among all the great men in that great city none was mightier than he.

And it came to pass when he knew of the afflictions of the Prodigy he was moved with compassion.

For he said, Surely I have known the struggles and misfortunes of a young man. And as I was given strength wherewith to triumph in my hour of need, so will I give my aid to those who need it.

By this he showed that he was not of the sect of professional philanthropists.

So he came unto the Prodigy and taking him by the hand he lifted him out of

the mire and put his feet on solid ground.

And he entreated him well and took him to his own place.

And when he had looked upon him and found him fair to see and possessed of good parts, his heart was warmed within him, and he made room for him at his own side.

And he spared nothing to spread abroad the name of the Protégé and to make for him a place among the learned of the city.

And because of his efforts the Protégé thrived and waxed fat and, in the fullness of time, he kicked.

Then was shown a mighty wonder on the face of the earth.

For it came to pass that he whose sandals were to cover all the land, increased not in his understanding though his head swelled beyond belief.

And he took unto himself foolish counsellors who said those things they thought would please him, rather than the things of righteousness.

And he listened to them until he boasted himself there was not another such an one in all the earth.

For he said unto himself, Behold me, what I am.

For am I yet a youth or am I come to manhood? Is it not time that I should show all men my greatness?

Was I not besought to come hither and let the light of my countenance shine upon those men more foolish than myself?

Did I not come and get my foot in it?

Yea, verily, not only my foot, but my whole body and my head, yea, even to the tips of my ears.

What though I was pulled out by one esteemed so great, is not the honor of helping me sufficient reward for any living man?

Verily he hath done himself credit in honoring me, but that I may not seem ungrateful I will accord him honor worthy of the Dwellers of Olympus.

For I will accept all the great and solid glory he has built up by a life-time of righteous deeds and pure wisdom, and use it as my pedestal, which all men, viewing from afar, will think to be my work.

And I will place him on a shelf where he may see and yet remain unseen, and he shall revel in the happiness of seeing men applaud his work, believing it of me who am so great.

When he had made an end of thinking, he cast about for means wherewith to do his will.

And he gathered together certain who considered it wicked to withhold their greatness from men who wot not of it.

Certain others also who possessed talents bearing the stamp of the government which made them legal tender for all things, save only brain and conscience.

And others likewise, who had sons or kinsmen not born great nor able to achieve greatness and upon whom they desired to thrust greatness.

Others also belonging to the sect of sore-heads and growlers, together with the professional philanthropists and all the dwellers in the holy land who love to sit in the high places and be seen of men.

These then took counsel together and joining all their wants, they went unto the Rulers of the great school and demanded of them the removal of the Pitiful Professor, together with three others who are likewise men of great reputation and teachers of ability, and to give their places to the Protégé and others like unto him.

Now, therefore, if the Rulers of the school hearken to these cunning men and are persuaded of them, the meaning of this parable will be made manifest to all men.

But what think ye those Rulers———

[The record is abruptly broken at this point, and we are left to conjecture whether this fragment is a prophesy, an admonition or an allegorical statement of current events. Further research will undoubtedly supply the missing parts and develop the sequel.]

# SOCIETY REPORTS.

## THE LOUISVILLE SURGICAL SOCIETY.

*February 7, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### CYSTIC TUMOR OF THE ORBIT.

DR. W. O. ROBERTS: This patient is sixty-one years of age. Forty-five years ago, that is when sixteen years old, he was kicked by a horse just above the brow, receiving a compound fracture of the outer table of the skull. He says that the brow seemed to be knocked down. The attending physician told him that the inner table of the skull was no injured. The wound healed, with marked depression at the seat of the blow. He had no trouble following the injury with the exception of headache; there was never any indication of epilepsy or anything of that kind. There was some defect in his vision, and he claims that his eye on that side was pushed down somewhat.

Twenty-nine years ago while chopping wood, a stick flew up and struck him on that side of the head, two splinters being driven into the eye-ball; a large piece struck him just above the eye, and he thinks pushed up that part of the brow which was forced down by the kick of the horse. The splinters which penetrated the eye-ball had to be removed by his family physician.

Two or three months after receipt of the last blow a tumor made its appearance just above the eye and near the nose, and, as he says, it pushed the eye considerably down and as it grew larger it extended to the right side, and has attained the size which you see now, being much larger than a man's fist. There is very little vision in the eye on that side; he is able to distinguish daylight from darkness, but nothing further. There has never been any acute pain from the growth.

#### DISCUSSION

DR. TURNER ANDERSON: I think the tumor is unquestionably cystic. In regard to the origin of it there is one point of interest to me in connection with the ridge of bone passing around the tumor, which is especially plainly marked at the upper portion. Wherever the pericranium is elevated, as we find in cases of bloody tumors in the head of new-born children, where the effusion is underneath the pericranium, between the bone and the covering of the skull, the pericranium being elevated, it very soon begins to throw out a line of bone and within a few days the blood seems to be contained as within a cup, the line of bone having extended all the way around it. These cases usually recover without treatment.

In the case before us I take it that the tumor is clearly cystic; the pericranium has been elevated by the effusion, and the imperfect line of bone at that point formed before the vessels became so thoroughly constricted that new bone could not be produced.

Dr. W. L. RODMAN: The case is certainly very interesting, and Dr. Roberts should have it photographed before he operates. There occurs to me three possible views in the case: First, it is possibly a dermoid cyst, for it occupies one of the favorite regions of the body for such growths. While dermoid cysts are congenital, they very often do not make their appearance to such extent as to be noticed until advanced life. They are more common near the outer than the inner angle of the orbit, although they do not occur in both situations.

Secondly, it may be a cyst which is growing from the frontal sinus.

Thirdly, it may be a cyst growing from the bone, probably the upper part of the wall of the orbit. It seems to me this view would be the most rational and more in line with the symptoms present in this case. In any event I am perfectly satisfied that it is a simple cyst. It could not well be malignant. Its duration, absence of pain and glandular enlargement, together with the excellent general condition of the patient emphasize the innocent nature of the growth. The irregular edge I think is due to the fact that the anterior or outer table is gone. I believe that the bone will be found necrotic. It is a simple cyst; probably dermoid in nature, either beginning at the angle or the roof of the orbit, and I believe operation should be performed at once.

There is another possible view of the case, which, however, is hardly probable, viz.: a sub-dural cyst. I operated upon such a case occurring in a negro boy at the University Clinic in 1889, Dr. Ray assisting me. Both the cyst and eye were removed and the case made an excellent recovery.

DR. J. M. RAY: It seems to me that the starting point of the growth before us is in the frontal sinus. The history of the growth beginning at the upper and inner angle growing toward the outer corner, looks very much as though the probable origin was in this local-

ity. Fatty tumors about the orbit are quite common, both congenital and otherwise. I have seen several such cases.

DR. A. M. VANCE: I do not think the growth before us is cyst; the contents seem to be semi-solid, and I believe it commenced in the orbit proper, from the history. I believe the orbit will be found to have melted away, also the bone above it has given way allowing the tumor to grow upward.

I do not see why it may not be malignant. I know that I have removed sarcomata from the head of people who looked just as healthy and in just as good condition as this man presents, which had been growing almost as long. I am inclined to think that this growth, if not originally malignant, is at present. I believe its contents is not fluid, but semi-solid. I certainly recommend its removal.

DR. W. O. ROBERTS: I have very little to add in closing. There is some question in my mind whether it is a cystic tumor, or a myxo-sarcoma. I think it comes from the orbit, and I told this man when he came to my office to-day that I thought it would be advisable to first aspirate the growth to ascertain the nature of its contents. It does not make any difference what it is, I propose to remove it. Myxo-sarcoma is about the slowest in development of any of the sarcomatous growths. It is not improbable at all, I think, that this is a dermoid cyst. I think it began in the back of the orbit, and did not show itself until after receipt of the last injury. I do not believe, however, the injury had anything to do with its occurrence.

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### A LARGE SARCOMA OF LEFT KIDNEY IN A CHILD FIVE YEARS OLD—NEPHRECTOMY—RECOVERY.

DR. W. O. ROBERTS: The first of last December I was called to Shelbyville, Ky., to see a child who will be five years of age the coming April. The history of the case was about as follows: The mother stated that four weeks prior to my visit, she noticed that the child's abdomen was much larger than it should be, and, examining it she discovered a tumor considerably larger than a man's double fist. The child had never complained of any pain or discomfort in any way. The mother was led to make the examination simply by the prominence of the abdomen.

While running about four days before my visit, the child had fallen flat on his face. He then commenced complaining a great deal about his abdomen and was put to bed. At the time of my visit his temperature was 100° F., and had been so for three days. There was considerable pain and tenderness over the left lumbar region; the child was lying in bed with the legs drawn up. Upon palpation, it was questionable whether there was fluctuation or simply elasticity of the tumor. I suggested that we aspirate to see whether the growth contained any fluid; this was done at three different points and nothing except a little blood secured. I then made the diagnosis of malignant disease of the left kidney. It was thought by the physician who had seen the case previously that the patient had disease of the spleen. I made my diagnosis chiefly upon the tympanites along the region of the colon.

I did not see the child again until the latter part of December. At that time the tumor had grown considerably; it filled the whole left side of the abdomen down almost to Poupart's ligament, and extended over about two or three inches to the right of the median line. The case was brought to this city for operation, and on January 17th, at the Norton Infirmary, assisted by Dr. Anderson and a number of other gentlemen, I made first a short exploratory incision—a perpendicular one—for the purpose of settling the diagnosis as to the organ involved; it proved to be the kidney as I thought. The spleen was perfectly normal as to size, but was pushed up, of course, by the growth. In this exploratory incision there was an opening made in a little vein on the surface of the tumor which bled very freely, and it was with difficulty the hemorrhage was controlled. I had explained to the father before making the exploratory incision that if the tumor was found of such a character that it could not be removed without too great a risk, the abdomen would be closed. When the bleeding occurred from the punctured vein, I, with the father's consent, went ahead and removed the tumor.

I did the operation suggested by Abbe, whose paper I had a day or two before seen in the *Annals of Surgery*, which consists in opening the abdomen transversely instead of perpendicularly. The short incision made was about two inches, I suppose, to the outer border of the left rectus abdominis muscle. I then carried the other across the abdomen one inch below the ribs back to the lumbar region and across the outer border of the rectus; that brought me down directly upon the growth. We found the descending colon so closely adherent that it was with some difficulty we were enabled to detach it. When we had dissected down to the pedicle of the tumor, the child seemed so nearly dead, that I did not take time to pick out the ureter but tied off the body *en masse*. I found that the tumor grew from the fibrous covering of the kidney, only a portion of the kidney seeming to be involved in the growth; the kidney, however, was removed in its entirety, as I was afraid the other portion might be infiltrated, and which could not be detected at the time. After removal of the

growth the wound was closed by three lines of continued sutures; it had to be done very rapidly owing to the extreme condition of the patient. The peritoneum was brought together first, then the muscular structures, then the skin and fascia. The child was put to bed in almost a moribund condition; however, he rallied and went along to recovery without an untoward symptom. He was discharged from the Infirmary yesterday in good condition, with the wound healed. The tumor which I exhibit for your inspection, was found to weigh immediately after its removal seven and a half pounds.

DISCUSSION.

DR. TURNER ANDERSON: I want to congratulate Dr. Roberts upon his success in this case. I think it was the most formidable surgery that I have ever witnessed. Dr. Roberts kindly permitted me to assist in the operation. The transverse incision extended around almost to the spinous process of the dorsal vertebra so that everything was thoroughly laid open. The adhesions to the descending colon were very extensive; the tumor was also adherent to the peritoneum and had to be dissected off. The whole procedure required the most pains-taking careful surgical work that I have ever witnessed.

DR. W. L. RODMAN: I also wish to congratulate Dr. Roberts upon the successful result in this case. It is the second case of nephrectomy he has had. I assisted him in the first case several years ago. The incision suggested by Abbe is perhaps a very good one; it certainly affords greater access to the kidney than the ordinary incision in front but it strikes me as being questionable whether this incision of Abbe is better than the older operation very much like it; that is, the operation of König, in which he begins posteriorly and cuts anteriorly. The only difference is that Abbe goes through the peritoneum, while König does not. König dissects up a large flap of the muscles and when he comes to the peritoneum it is pushed forward toward the median line, in that way he removes the kidney without doing injury to the peritoneum. The disadvantage in either operation would be the great liability of ventral hernia. While the result in Dr. Robert's case is very gratifying so far as the primary result is concerned, I am very clear in my own mind from statistics on the subject that these operations are done more to show what can be done with the knife than for any real substantial good that comes to the patient. Gross and others have shown very clearly that the mortality of nephrectomies for malignant disease is frightful; in the lumbar operation about thirty per cent., in the abdominal operation about forty-five per cent. One reason why the abdominal is perhaps more fatal than the lumbar operation is that severe cases are operated upon by the anterior route; you cannot remove as large a tumor by the posterior as by the anterior route. So when you consder that the mortality in these cases is forty-five per cent. further, that no single case of cancer of the kidney has ever passed the three years limit after operation and that very few sarcomas have passed this limit; that many of them die on the table; others dying a few months after the operation; again, the liability of ventral hernia occurring it strikes me as being very questionable whether this operation ought to be done or not.

DR. H. H. GRANT: I agree in the main with what Dr. Rodman has said in reference to operations for the condition under discussion, but in this case it appears that great benefit has been done to the child by the operation, and its life is probably prolonged. If this tumor is really a sarcoma, it is barely possible that the child will entirely recover, although as Dr. Rodman says these operations have not been done very frequently for sarcoma. I believe it is possible in some cases to cure sarcoma of the kidney by complete removal. Several cases are recorded of the prolongation of life and addition of comfort after such steps.

With respect to the post-peritoneal operation for a condition of this kind: Although I have never had an opportunity to see an operation of this character performed it seems to me that in the majority of cases where a tumor of this size is present, it would be almost impossible to remove it without doing injury to remove it without doing injury to the peritoneum, and as at the present day we feel but little hesitancy in invading the peritoneal cavity, it is perhaps just as well to bodly open it as suggested by Abbe, and understand in the beginning just what we were cutting without fear of after results from invading the peritoneum. It seemed to me when I read Abbe's paper that it would not be an unwise thing to make posterior opening through the lumbar region at the time, which would allow thorough drainage and still not disturb the decubitus of the patient. It seems to me this would be an important additional step in the operation, and I believe if I had occasion to do an operation of this kind I would supplement anterior drainage by making drainage in that region.

DR. W. O. ROBERTS: As Dr. Rodman says this is the second case I have operated upon for malignant disease of the kidney, the first one being in 1885. This patient was referred to me by Dr. Anderson, who also rendered valuable assistance in the operation, and in that case there was recurrence of the trouble and the patient died inside of three months.

However there was prompt recovery from the immediate effects of the operation. Regarding the mortality in these cases: Statistics show that about fifty per cent., according to Abbe, die from the immediate effects of the operation. I think Keyes reports a case that lived four years after operation.

In my second case when the operation was undertaken, the father was advised of the opinion of all the gentleman present that it was almost certainly a sarcoma; we told him that if we found it to be a sarcoma and thought it best not to go on with the operation because of that fact, we would simply close the wound; but when the troublesome hemorrhage occurred I saw it would not do to close the wound, hence after consulting with the father, went ahead and removed the growth.

Referring to Dr. Grant's remarks concerning drainage: I will state in this case drainage was made from the posterior angle of the wound, with strips of iodoform gauze put down to the bottom of the wound which drained very satisfactorily. This was removed at the end of forty-eight hours, and another small piece introduced which remained until the second dressing, then no further drainge was made. I think the operation as performed in this case decidedly best where the tumor is large.

The advantage of incision at the outer border of the rectus muscle (Lanenbeck's), over the one in the median line, is that you go through the outer layer of the mesocolon and avoid the vessels lying in the inner layer, and hence avoid the danger of sloughing of the gut. In the operation I performed in the case just reported there were no vessels to be tied.

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SEPTIC PNEUMONIA RESULTING IN GANGRENE.

DR. W. L. RODMAN: On December 15, 1893, a young man, Mr. E. H., aged twenty-eight years, while working on the Louisville and Jeffersonville Bridge, fell with a span of the bridge a distance of rather more than one hundred feet. He was not able to say whether he was struck by any timbers or iron in falling. He received a fracture of the fifth, sixth and seventh ribs of the left side. The shock was quite profound but he recovered from it with reasonable promptness. It was noticed at once that one of the ribs must have penetrated the lung as he spat blood copiously with each expectoration, and air could be felt in the cellular tissue over the fracture. This became more marked during the day until the whole side of the chest was quite distended with air, which also passed down the left side of the body; the scrotum was especially distended being as large as a child's head. He got along very well for three days never having a decided rise in temperature, suffering only at times from short, painful paroxysms of coughing. On the fifth day there was an elevation of temperature, it reaching a point as high as 104° F. That was the beginning of as severe a case of traumatic pneumonia, which was, of course, septic in nature, as I have ever seen. The left lung was solid from apex to base. He had a hard time getting over the pneumonia, but on the fourteenth or fifteenth day he showed symptoms of improvement; the temperature remained very high, hardly ever less than 104° F.; there was no effusion in the pleural cavity. On the sixteenth day his temperatnre dropped somewhat, and he commenced expectorating a great amount of very offensive matter. It was so extremely offensive that it made all the nurses and patients sick. It was necessary to keep all the windows open, although the weather was quite cold. There was evidently gangrene of the lung, he soon went into a condition of profound sepsis, and I had very little doubt but that he would die. While the temperature was low he had at all times a very copious sweat, the pulse became very frequent, 130 to 140, the skin had that peculiar muddy appearance of sepsis, and he was in a very critical condition. A consultation having been held, it was thought advisable to resect his rib and to see if we could not find the original opening in the lung, and following that as a guide open up the abscess in the gangrenous part of the lung. This was done, I think, about the twentieth day after the accident. The sixth rib was resected, a piece about four inches in length being removed. I used the Rongier forceps, which, by the way, I shall always use hereafter, as I consider it the best instrument for the purpose. Pus was encountered as soon as the rib was cut; the original opening in the lung was easily detected, and a large abscess was found in the gangrenous portion of the lung. The lung was packed with several yards of gauze in strips, and the man's recovery has been very gratifying indeed. He was better the day after the operation and has improved steadily ever since. The abscess was in the upper lobe of the left lung. He spat up the foul stuff for a week after the operation, some of it drained out through the incision, and for the last month he has seemed to be perfectly well. He is able to walk about the Infirmary, is gaining flesh and strength, and altogether his convalescence has been very satisfactory. Pus was discharged from the wound for three or four days; after that time the discharge was only from the superficial part of the wound. It was packed every day for about eight or ten days and then allowed to heal.

DISCUSSION.

DR. TURNER ANDERSON: I was very much interested in Dr. Rodman's report. As we understand pneumonia, I have been under the impression that such a thing as *traumatic pneumonia* was impossible. We may have an abscess or inflammatory process involving the lung, but a veritable *traumatic pneumonia* as we understand pneumonia, is hardly admissible. Of course, the treatment in these cases is plainly indicated as soon as the abscess is detected, as soon as the lung becomes gangrenous—to practice external drainage.

In this connection I wish to claim priority in the matter of practicing external drainage in pneumonia, as I believe I was the first to attempt such a procedure in this part of the country. The case was one of ordinary pneumonia which terminated in gangrene of the lung; it was a severe case in which I aspirated the lung, then enlarged the opening and practiced external drainage between the ribs. The rib was not resected, and I believe that in many of these cases free drainage may be obtained, without removing a portion of the rib, by making an opening in the inter-costal space and inserting a drainage tube.

DR. W. O. ROBERTS: I also wish to congratulate Dr. Rodman; certainly he carried out the proper procedure. The patient was in a very critical condition, and the doctor is deserving of great credit.

DR. T. S. BULLOCK, (Visiting): I have seen with Dr. Anderson two cases similar to the one under discussion, where recovery followed very promptly. In the first case after aspirating, a drainage tube was passed through the intercostal space and thorough drainage established in that way. In the other case he did a resection of the rib and recovery followed promptly. I must say that I never saw such an amount of pus escape from any cavity as was discharged in the last case.

DR. JAS. S. CHENOWETH: I was present when Dr. Rodman operated upon the case referred to. While the patient did spit up a large quantity of very offensive stuff, I was particularly struck with the small amount of pus liberated at the operation. I was rather impressed that there might possibly be a collection of pus which was not reached; however, the patient was very promptly relieved, and it is evident all the pus was removed. I was struck with the small amount of pus and the very grave symptoms.

DR. J. G. CECIL: I want to ask one question in reference to puncture of the lung by a fractured rib. As I understood the reporter, it was evident from the beginning from the symptoms already detailed that the rib had been fractured, and that it had wounded the lung. Would it not have been good surgery therefore to have made an incision in the region of the fracture as soon as the man recovered from the shock of the accident, and searched for the rib which probably projected into the lung? It occurs to me that this would be good surgery, and might have prevented after trouble such as Dr. Rodman has described.

DR. W. L. RODMAN: I am glad Dr. Cecil has brought up the question of early operation in these cases, and the point he makes is an excellent one. I was tempted to make an opening in this case the second day after the injury. I went over all the literature of the subject very carefully and could find nothing to warrant me in such a course. The books simply state, "In case of depressed ribs, where you are satisfied the lung has been injured, the proper procedure is to take a blunt hook and go down into the rib and aim to pull it up in that way." I did not believe any good would come from such a procedure, so did not attempt it. The next case of the kind I have I shall not hesitate to do as Dr. Cecil suggests; certainly it is the proper procedure in such cases, and there is no danger in removing a piece of the rib, when it is already as in this case a compound fracture, air entering from within.

In regard to the point made by Dr. Anderson: I am perfectly familiar with the fact that the larger majority of medical writers say that we do not have *traumatic pneumonia*. I do not mean to say that in these cases we have the *pneumococcus*, but I do say that this man's lung was solid from apex to base. Another man hurt the same day who is still in the Ward, had the same kind of an injury, although he has not had emphysema and the lung did not become gangrenous, but it was solid from top to bottom—evidently a septic pneumonia. I am thoroughly convinced that any man examining the two patients would have pronounced one lung of each perfectly solid from top to bottom; whether it was pneumonia or not, you can decide for yourselves,—each had the rust-colored sputum, the characteristic respiration, pulse and temperature of pneumonia, and neither at any time had any fluid in the pleural cavity.

DR. W. O. ROBERTS: It is not unusual to have an injury of the lung and fracture of the rib without an abscess; Dr. Chenoweth will remember a case that we exhibited before the class at the University not long ago, where the man had a fracture of the second rib with emphysema. The man recovered without the slightest trouble and without operation.

I do not think it advisable to do this operation in fracture of the rib until there is evidence of suppuration.

DR. W. L. RODMAN: If you knew there was a penetrating wound of the lung, do you not think it would be good surgery to operate at once?

DR. W. O. ROBERTS: Just as soon as there

was evidence of suppuration, then operation should be performed, not before.

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Dr. I. N. Bloom read a paper on

URETHRITIS—SIMPLE AND SPECIFIC.

(See page 705.)

DISCUSSION.

DR. H. H. GRANT: I do not speak of these cases from a specialist's standpoint, but it occurs to me that both cases Dr. Bloom describes may be easily explained. In the first case I believe that his patient most certainly had simple urethritis, and it is entirely possible for simple urethritis to have produced this irritation in the woman. I am sure that I have seen a number of cases of urethritis which were simple in the male, certainly cases in which there were no gonococci present; perhaps in many instances there was certain irritation, the result of old strictures producing long-standing trouble, that infected the wife afterward; and while I believe, as Dr. Bloom states, that it is not possible to bring about a cure for gonorrhœa in four or five days, yet I do think it possible for simple urethritis to get well in that length of time to all appearances, and yet afterward may cause vaginitis, urethritis, etc., in the female.

Referring to his second case: A great many cases of gonorrhœa are supposed to be cured while there still remains in the glands, far back in the prostatic portion of the urethra a quantity of the gonococci which are not in active irritative and aggressive condition, yet they are present and may become disloged and pass out with the urine or with the semen in sexual intercourse, and in the latter case they are ejected into the female vagina and may be productive of serious trouble. I think there is almost no question about this being the course of infection in the second case reported by Dr. Bloom, and I can see no other rational explanation of the first one. I am sure Dr. Bloom will say without hesitation that a very large number of cases of gonorrhœa are apparently cured, still there may be retained somewhere, either in the epithelial covering of the urethra or in some of the glands or pockets far back, germs able to cause gonorrhœa for a very considerable length of time, even after all manifestations have apparently been cured, and this, too, without there being any particular irritation in the male, or at least any irritation that he is able to define as result of the urethritis. Certain symptoms are nearly always present in individuals who have suffered long from gonorrhœa which remain for a considerable period of time, certainly for a year or more after apparent recovery; the patient feels a sense of discomfort in the prostatic portion of the urethra almost invariably, and sometimes even higher up there is that condition known as gonecystitis. It is exceedingly common for conditions of this kind to exist long after the original trouble has disappeared.

DR. J. G. CECIL: The cases reported by Dr. Bloom are very interesting to me. Certainly we know it to be a fact that gonorrhœa may exist for a long time in the genital passages of women, in the glands of Bartholini, in the cervix, in the posterior vaginal fornix, and in many places almost inaccessible which generally are overlooked or neglected in any method of treatment that is adopted. The question as to how long gonorrhœa may exist either in the male or female, and how long it may possibly be communicated is one to which I have never been able to give any satisfactory answer, and shall be very glad if Dr. Bloom, in closing, will enlighten us in this particular.

I can hardly agree with Dr. Grant that simple vaginitis will show up in as virulent a form as indicated in the case reported by Dr. Bloom. We may have simple vaginitis occasionally, but I have never seen it involve the urethra to any extent. I have seldom seen it extend to the pelvic region and involve the tubes; in fact I hardly think it is probable that simple vaginitis will ever result in these complications. I am free to say that I can not understand how the first case described by Dr. Bloom could have originated. The second case, especially in its relation to the time when it is advisable for persons to marry after having had gonorrhœa, strikes me as being one of very great moment, because of the prevalence of gonorrhœa among young men, and especially since we know the wonderful number of diseases in the female that result from so-called cured gonorrhœa. I had a case in mind at the time Dr. Bloom was speaking, of a gentleman whose wife had been suffering from some womb trouble, who had, of necessity, to live apart from his wife and had indulged his fancy outside contracting gonorrhœa. He came to me for treatment while his wife was going to another physician for treatment. I persisted with and urged upon him the necessity of complete cure before he again went to stay with his wife, and thought that I had accomplished this, and he thought so, too. Every symptom had disappeared, and he went so far as to make a crucial test by going outside again and trying it on somebody else, and utterly failed in his attempt to communicate the disease. Three or four weeks after all symptoms had subsided he communicated gonorrhœa to his wife.

It is a question that it seems to me ought to be settled in some definite way if possible, because of its importance. Of course no man wants to communicate gonorrhœa to his wife, whether she be newly married or otherwise, and especially since we know that so

many pelvic diseases which require extensive operative procedure to relieve are due to gonorrhœa, it seems to me the quesion ought to be discussed and settled. I am sorry that I have not something definite to offer, but it seems to me that Dr. Bloom in the cases he reports did follow out every possible precaution that even the most exacting of us could have asked, and yet his cases went wrong. The question will come up to all of us, When can a man marry after he has had gonnorhœa with safety? When should he be allowed to marry?

DR. I. N. BLOOM: I feel very much gratified that the cases I mentioned have been so thoroughly and ably discussed. My object in citing these two cases was to get the different opinions on the subject. I am fully cognizant of the experiments and tests that have been made as to the cause of gonorrhœa, and as yet I am not satisfied and not prepared to state that the germ of Neisser is not the specific germ of gonorrhœa; on the other hand I am also not prepared to state positively that it is the essential germ which produces gonorrhœa.

As regards the first case: Dr. Cecil has answered Dr. Grant exactly as I should have done. I do not believe simple urethritis could possibly produce the symptoms which were seen by one of the physicians present who was called in consultation when peritonitis developed.

In the second case, the man married early in October and had intercourse with his wife during October, November and a part of December before she developed any symptoms of gonorrhœa, and the strangest feature is without a single symptom developing in himself. It is natural to suppose any latent urethritis that might exist would be aggravated by sexual congress the first few weeks of marriage and be at once communicated; I believe that is the usual history of these cases. However in this case nothing in the wife until fully two months after marriage. Some writers claim that a man may be absolutely free from all symptoms for a year, and then communicate gonorrhœa; while such cases may sometimes occur, I believe they are extremely rare. Further, do not some authorities recommend marriage for the cure of so-called gleety discharges in the male, and have not cures resulted in some cases, without any trouble developing subsequently in the female? Yet here is a case where exactly the opposite condition exists—there was absolutely no sign of urethral discharge for a period of several weeks before marriage, all evidence of gonorrhœa having disappeard, yet the wife became infected. We could all cite cases where a discharge was still present, the patient married became well, and the wife was not infected. I do not believe that the gonococci can exist in any part of the urethra for along time sufficiently active to give a specific gonorrhœa to anyone, without causing trouble, and specific trouble at that, in the patient himself.

I am satisfied the cases I have reported might be multiplied by many others, and because of the importance of the subject I think they are worthy of discussion and publication. In regard to the specificity of the bacillus of Neisser—I do not think it has been fully established, clinically at least.

DR. BODINE (Visiting): I understood Dr. Bloom to say that his patient had at one time what was regarded as specific urethritis, that the gonococci were present. Is it not possible that some of these gonococci invaded the ejaculatory ducts, during the progress of the urethritis and there remained quitely, producing absolutely no trouble?

By treatment may we not destroy all the the gonococci in the urethral tract, but may not some of them during the active stage get into the ejaculatory ducts and remain there? No examination of the urine in such a case, no matter how frequently repeated would disclose their presence, but during the ejaculation of semen in sexual intercourse they might be transmitted to the female. I can understand how this might occur, and simply offer this suggestion as a possible explanation of the infection in the case reported by Dr. Bloom.

DR. I. N. BLOOM: The tendency of the gonococci is to increase and multiply, and I believe all experiments in this direction show that they never lie in a latent quite condition, but are continually developing.

DR. H. H. GRANT: I agree perfectly with what Dr. Bodine has said, and simply rise to answer Dr. Cecil: In the present history of diseases of women, am I not correct in saying that there are certain authorities who maintain that no woman ever marries a man who has had gonorrhœa but suffers in some way from the effect of that gonorrhœa?

There is abundant authority in every surgical journal of the land, and in nearly every surgical book to support the statement I made that gonnorrhœa is not by any means cured when the discharge ceases and that in many instances the disease remains latent for a very considerable time. Therefore if it be true, as maintained, that any woman who marries a man who has had gonorrhœa invariably suffers from its effects, it would seem to me that if a man marries a woman within a period of two or three years after he has apparently recovered from an attack of gonorrhœa, it is perfectly possible for the gonococci to produce such effects as Dr. Bloom has described.

The question as to when it is safe for a man to marry after having apparently recovered from an attack of gonorrhoea is one of the greatest importance, and one which in my opinion is far from being satisfactorily settled.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE MEDICAL CHRONICLE

of Manchester, England, for April. Dr. Julius Dreschfield contributes a paper on a

**Peculiar Form of Idiopathic Intermittent Fever of Pyæmic Character.**

The author states that there can be little doubt that the disease is microbic in its origin. He saw in all six cases, they were all men, their ages varying from 23 to 56. All, with two exceptions, had enjoyed good health up to the time of the onset of the disease—one had suffered for some time from the symptoms of alcoholism, and one had had glycosuria for several years before the febrile attack set in. Not one of them had lived in a tropical or malarial climate, nor had any of them ever had malaria, rheumatic arthritis, or any injury. In four out of the six cases the disease was fatal.

The principal symptom noticed in each was a pyrexia, not unlike that seen in intermittent fever—namely a rigor, during which the temperature would raise to 103° F., and sometimes to 107° F. This was followed by the hot stage, and this was succeeded by the stage of sweating; the perspiration, in some of these cases, was so profuse that the clothes of the patient, and even the bed clothes, were soaked through and had to be changed.

The pyrexial attack was followed by a febrile period, during which the temperature was normal or subnormal, and during which time the patient felt quite well. In some of the cases the temperature between the rigors was somewhat above the normal, but yet the patient did not appear to suffer any inconvenience. The rigors occurred in a few cases regularly once a day, generally in the evening, in other cases they occurred at very irregular intervals. Sometimes there were two or three rigors within twenty-four hours, at other times there was no rigor for several days. This irregularity occurred in the same patient.

Abdominal pain was present in three out of the six cases from the first. The pain was not localized nor did it occupy the same position in all; in two it was over the region of the liver, in one over the epigastrium, and in the fourth a mild diffuse pain was felt over the abdomen. In some the appetite remained good throughout, in others there was occasional vomiting, and in one persistent vomiting; constipation was present in all. In none of the cases was there noticed any affection of the lungs or heart. The pulse was steady and slow during the febrile period, and rose quickly to 100 and more during the fever stage. The spleen was found slightly enlarged in all cases. The urine showed little that was abnormal; in only one case did the author detect albumen and hyaline casts in the urine, which was passed about one hour after the sweating stage, and this occurred several times in the same case. The diazo-reaction was absent in the three cases in which it was tried. An important and noteworthy symptom in three out of the six cases was an enlargement of the liver; but this came on some time after the onset of the disease. Two of these cases terminated fatally (in one of them very slight jaundice appeared a few days before death), and the liver was found to be the seat of suppurative hepatitis. In the third case jaundice came on about six weeks after the onset of the disease, the liver enlarged enormously, but after a time both the liver intumescence and the jaundice gradually disappeared, and the patient made a satisfactory recovery.

Though the prominent symptom in all was the intermittent fever yet the author is certain that the cause was certainly not due to malarial poison, for the patients did not live in a malarial country, and none of them had ever had malaria; the spleen was only slightly enlarged, and increased in size only with the progress of the disease, and quinine, arsenic, and even methylene blue, had no effect whatever on the pyrexia, nor did the attack of pyrexia show any periodicity. In support of the view that the disease is of pyæmic origin, the author cites (1) the suppurative hepatitis which was found in two of the fatal cases; and (2) the relation of the disease to some pyæmic affection, namely, pylophlebitis and ulcerative endocarditis. (3) The presence of numerous micro-organisms in the liver in one case.

The author, therefore, regards the disease as pyæmic and due to a micro-organism which probably enters the system through the digestive tract, and reaches the circulation either through the portal vein or the lymphatics. Either it, or the toxines produced by it, causes the peculiar symptoms, and if arrested in its course, say in the liver, and not destroyed there, it may give rise to suppurative hepatitis, though it is possible that if suppurative hepatitis occurs, this may be due to a second infection. The author is unable to say as to the nature of the micro-organism further than that it appears as numerous clusters of small thick bacilli which appear in close relation with the billiary passages, and in their appearance not unlike the bacterium coli commune.

In the treatment of the affection the various antipyretics, quinine, sodium salicylate, antipyrin, antifebrin and phenacetin were used, but none of them appear to have had any good effect. Large doses of quinine, and arsenic, showed no immediate effects in these cases. Methylene blue given in one case appeared to aggravate the symptoms. The recovery of the two cases, the author thinks, was due to the fact that the patients could take a very fair amount of food, and that in this way the patients had sufficient strength to resist the devastating effect of the micro-organisms, whose natural term of life eventually expired.

Thomas Jones, F.R.C.S., discusses

**Cancer of the Rectum and its Treatment by Excision.**

In cancer of the rectum, as in cancerous affections generally, it is of the utmost importance that the condition should be recognized before the disease has made much progress. The early symptoms are often insignificant, the patient perhaps merely complains of vague pains in the rectum, or notices that he is becoming more and more constipated. The author impresses the great need for a more regular and systematic examination of the rectum whenever the symptoms point, however indistinctly, to disease situated in that region. Little good can be effected once the affection has involved the tissues outside the wall of the gut. The necessity for a rectal examination in every case of persistent diarrhœa must ever be in the mind of the surgeon.

When the new growth is nodular and very extensive, often almost encircling the gut, the passage of feces will be seriously interfered with, and obstruction may at any time arise. Glandular enlargement may take place late in cancer of the rectum—a fact of considerable importance in regard to the question of operation. The examination, which should be carried out with care and gentleness, is to elicit information on the following points: The character and extent of the disease, and the condition of the rectum as regards mobility upon the other pelvic structures. In this manner is to be settled the question as to whether the disease has travelled beyond the limits of the intestinal wall, and on this hangs the propriety of attempting to remove the disease by excision. It is also possible by digital examination to determine whether the lymphatic glands are enlarged or not; those in the hollow of the sacrum, when enlarged, may be made out through the wall of the rectum.

The author divides the operations for the relief of rectal cancer into two classes: (1) those that aim at the relief of urgent symptoms, and (2) those that have for their object the complete removal of the diseased mass. Among the former, colotomy offers the best prospects. It not only relieves the sense of weight and uneasiness in the part affected, and removes all chance of obstruction, but checks the progress of the disease, and places the patient in a state of comparative comfort. In regard to the question as to whether this operation should be resorted to early or only when the symptoms have become well established, the author states that he is against waiting until the disease has made serious inroads upon the patient's strength. Removal of the cancerous growth by the free use of the scoop or of the fingers may relieve the spmptoms of obstruction, and should perhaps be adopted when other means are not available, though this and linear proctotomy have little to recommend them.

The radical cure of rectal cancer can only be effected by free excision from the perineum, but if the operation is adopted indiscriminately it is certain to fall into disfavor. The merits of each case, as it presents itself to us, must be carefully weighed, and only those cases operated upon in which there is a reasonable prospect of removing the whole of the disease. Before a final decision is arrived at, the rectum must be explored while the patient is under the influence of an anæsthetic, and attention directed to the following points: The extent of the disease and the state of the rectum in regard to mobility in the pelvic space. Regard must also be had to the general condition of the patient with respect to strength and nutrition; his age; as to whether there is any evidence of the disease affecting parts outside and adjacent to the rectum; also, whether there are any symptoms to show secondary deposits in the liver or elsewhere.

The author considers the objection to Kraske's method of operating (by removing the coccyx and left lower part of the sacrum to obtain space for the necessary manipulations and bringing the rectum down to the skin surface) is not founded on any substantial basis. Cripps objected to this on the ground that it favored the production of pockets outside the rectum, in which decomposing fluids might accumulate, but the author has brought down and fixed the entire circumference of the rectum, or a considerable portion of it, and has never witnessed any ill effects from the practice.

In regard to the condition of the patient after the operation and the prospect of a complete cure, the author says that his condition will compare very favorably with that obtained by colotomy, and is infinitely preferable to that in which a patient with advanced cancer finds himself. In most instances the patient recovers sufficiently to enjoy life, and even to resume active work, and it is possible that the disease may not show itself locally, but return in some internal part where its ravages are less dreadful to witness. Besides this, the moral effect of total removal of the disease cannot be overestimated. With regard to the possibility of complete cure, the author quotes the statistics of Cripps: In nine out of twenty-three cases the disease recurred after periods varying from four months to two years, but six remained well after intervals which varied from two to four years.

The author closes his paper with an earnest appeal for early diagnosis. If the disease is allowed to travel outside the limits of the gut the only chance of obtaining relief is by colotomy. To perform excision under these circumstances is to put the patient to needless pain and discomfort.

W. J. Sinclair, M. D., discusses

**Ventrofixation of the Uterus.**

The author believes that the bad result in those cases where the uterus is reported as having returned to its original position was due to the operator having used too few stitches to keep up a permanent connection between the uterus and the abdominal parietes. It is of valuable assistance in the operation, he thinks, to seize the fundus uteri exactly in the middle with a sutiable small volsella, which can be held by an assistant, and the uterus can thus be drawn by him in the

direction which is most favorable to the completion of any necessary manœuvre. An important point in the operation is the introduction of sponges behind the uterus, immediately on its being drawn forward. by the volsella; these clear the field of operation and prevent injuries of the intestines or any manipulation of them. A drainage tube has been used only when it was necessary to tear down considerable adhesions which might be expected to bleed. The external dressings, when no tube was used, consisted of lint soaked in carbolic acid and glycerine. This was covered with gutta-percha tissue, and occasionally above the tissue is placed a soft flat sponge. The dressings are then kept in position by strapping. The sponge keeps up a gentle elastic pressure, and is not too thick to interfere with the advantages obtained from the use of an ice bag when reaction appears too strong. As it is essential to keep the patient lying on her back at first, the author has invariably introduced a glycerine-pad pessary of the Hoge shape to support the uterus until the adhesions might be assumed to be firm and permanent.

The author reports a number of cases and ends his paper with the following conclusions:

1. The various published series of cases show that the element of danger is almost *une quantite negligeable*. The present writer's series supports this opinion.

2. The operation, efficiently performed, is a permanent cure of the troubles arising from chronic retroflexion of the uterus, complicated with adhesions or inflammatory affections of the tubes and ovaries.

3. When pregnancy occurs after the operation no distress is experienced by the patient, and no unusual phenomena are observable during the pregnancy, parturition, or the puerperal state.

4. Contrary to what might be expected, bladder troubles are quite the exception after the operation, and these discomforts are almost certainly avoidable by care in operating.

5. In a certain proportion of the cases ventral hernia occurs at the site of the cicatrix. How this is to be prevented is one of the problems of the future.

6. After making full allowance for the element of risk and the incidental drawbacks, the operation of ventrofixation is not only justifiable, but is indicated in a certain limited class of cases of retroflexion of the uterus with complications.

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THE EDINBURGH MEDICAL JOURNAL

for May contains the conclusion of the paper by John Wyllie, M. D., on the "Disorders of Speech," this number dealing with "Dysarthric and Anarthric Disturbances of Speech due to Lesions Affecting the Motor Speech-tracts" especially the lesions in the second trophic realm. There is also a second instalment of the "Morison Lectures on Insanity" delivered by John Batty Tuke, M. D.

Francis D. Boyd, M. D., contributes a paper on

**The Relative Proportions of the Two Proteids in the Urine in Cases of Albuminuria.**

As the result of many observations made by him in cases of acute nephritis, chronic interstitial nephritis, amyloid disease of the kidney, albuminuria of pregnancy and albuminuria of heart disease, the author comes to the following conclusions:

1. That in albuminuria both the proteids of the blood and serum are present as a rule, but there are certain exceptional cases where this does not hold.

2. That we cannot diagnose the form of kidney lesion from the proportions of the two proteids in the urine.

3. That the proportions of serum albumin and globulin may vary widely in albuminous urine.

4. That even in amyloid degeneration, where the patient is very emaciated, the globulin may not be in excess.

5. That in the albuminuria of pregnancy, both serum albumin and globulin are present, the tendency being for the globulin to be in proportionally large amount.

6. That in the albuminuria of heart disease, where there is no chronic kidney disease, the globulin is usually in larger proportion than is commonly found in chronic interstitial nephritis.

7. That in acute nephritis, where there is no hæmaturia, the serum albumin and globulin are, as a rule, about equal to in proportion; but when there is blood in the urine, the globulin is proportionally large in amount.

J. Ryland Whitaker, M. D., contributes a note on

**The Relations of the Axillary Artery.**

Quoting from Quain's Anatomy, the author states that the usual description given is as follows:—"First part of the axillary artery—The nerves of the brachial plexus are to the outer side, the external anterior thoracic nerve crosses in front, and the internal and posterior thoracic nerves behind. Second part.—The three cords of the brachial plexus are placed one on the outer side, the second behind, and the third on to the inner side." The author makes quotations from other works on anatomy with all of which he finds fault in that they make no mention of the passing of the inner cord of the brachial plexus behind the artery. According to the author, the relations should be stated as follows: "The cords of the brachial plexus lie to the outer side of the first part of the axillary artery, and at the junction of the first with the second part, the inner cord passes behind the vessel and gets to its inner side, so that in the second part of the course of the artery the cords of the brachial plexus lie, the outer cord to its outer side, the posterior cord behind, and the inner cord to its inner side."

A. G. Miller, F. R. C. S. E., reports a case of

**Acquired Tubercular Disease of Hip and Shoulder Joints.**

The patient, whose case is reported at great length in the paper, had been nursemaid for six weeks to an intensely tubercular child. The girl herself had a good family history and had previously been healthy, without

any suspicion of tubercular disease. At the end of the six weeks she developed tubercular disease of the hip and shoulder, and finally of the lungs. Pus from the affected joints was found to contain tubercular bacilli. The girl died a year and nine months after the commencement of the disease. The author accounts for the infection thus: "The girl being a considerable part of the day with the tubercular boy, feeding him, kissing, washing and dressing him and his sores, must have inhaled, and possibly swallowed, a considerable number of bacilli. In some way which we do not perfectly understand, these bacilli passed into the circulation, and were thus potentially in every part of the girl's body. From the cold and damp of the room in which she slept (the season being winter) she acquired an arthritis, probably of a rheumatic character. This arthritis affords an opportunity for the establishment of a colony of tubercle bacilli which, at first slowly in the shoulder joint, and then more acutely in the hip joint, carry out their usual work of destruction. Later on they establish themselves in the lungs, and produce a fatal issue."

The author acknowledges that it is always very difficult to prove direct infection. In this case he claims that at least the presumption is very strong that the nursemaid acquired her tubercle from the child she had charge of. He publishes the case because he thinks that sufficient care is not always taken to prevent such unfortunate events occurring, and because many are not aware of the risk.

A. Lockhart Gillespie, M. D., presents a review of "Recent Gastric Literature," and Allen Thompson Sloan, M.D., contributes a paper on "The Geographical Distribution of Goitre."

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## THERAPEUTICS.

### The Subcutaneous Infusion of Common Salt for Acute Anæmia.

Dr. O. Feis (*Therapeutiche Monatshefte*, February, 1894) reports three cases of extreme anæmia after abdominal surgical operations, in which the injection of common salt was apparently the means of saving life.

The instruments for subcutaneous infusion are perfectly simple. All that is needed is a tolerably strong canula, a rubber tube, and a funnel.

The infraclavicular region is the best place to make the injection; the skin and all instruments are disinfected in the usual way, the skin raised in folds, and the needle, with the salt solution flowing (to prevent the introduction of air) inserted. From a moderate height the fluid is let flow, the funnel being kept full. If too much collects under the skin, it is stroked away with a gentle massage.

In from ten to fifteen minutes one quart may be infused in this way. The place of the puncture is finally closed with sterilized cotton batting, fastened with sticking-plaster. Drs. Feis and Schwalm have prepared pastilles of chemically pure salt, which physicians may have always at hand.—*Therapeutic Gazette.*

### Valerianate of Amyl.

Blanc (*Rev. de Therap. Med.-Chir.*) describes valerianate of amyl, which is the odoriferous principle of the apple,—that is, the essence extracted by distillation together with alcohol. Cider has long been believed by the laity to have some effect on calculous formations, and this seems to be borne out by the fact that valerianate of amyl really has some solvent action on tholesterin. It is a colorless liquid, of pleasant taste when taken in small quantities, and can be prepared in the laboratory by the action of valerianic acid on amyl alcohol; 1 grain of cholesterin is dissolved by 4½ grains of valerianate at 37°C. and by 8 grains at 40°C. Physiologically the action resembles that of ether, but the special qualities lie in its being a stimulant and sedative to the liver in cases of hepatic colic. It not only immediately subdues the attack, but it prevents recurrences. If the stomach is irritable, it may be necessary first to employ sulphuric ether, following this with two to three capsules of fifteen centigrammes each, given every half-hour until the crisis is past, and continued at longer intervals during the following days. In nephritic colic the drug acts as an antispasmodic and general stimulant only, but no effect is produced on the renal calculi. Muscular rheumatism is frequently relieved, and much benefit is also derived from its use during menstrual uterine contractions. As a sedative, it is of value in hysterical manifestations. Its toxic properties being very slight, as many as five to six capsules can be taken daily, but it is necessary to guard against gastric disturbance.—*British Medical Journal.*

## MEDICINE.

### Ichthyol in Pruritus.

In the vaginal pruritus of pregnancy, ichthyol has been found very useful. It may be employed in the form of an ointment, made up with lanolin. In some of these cases it has given relief where carbolic acid and cocaine have failed (*Ex.*). In the pruritus, also of diabetes, the drug has proved to be very useful, combined with fifty per cent. of glycerine.

### The Aetiology of Headache.

In a recent number of the *Revue Generale de Clinique et de Therapeutique* Dr. S. Vermel, after a thorough study of the subject, says that he is inclined to attribute all headaches to an oversensitive condition of the sympathetic nerves controlling the peripheral vessels of the cranium and brain, or to an angeioneurosis. It may be asked at once, he says, how the same symptoms, from the same cause, can be present in diametrically opposed conditions, such as plethora and anæmia, febrile and apyretic diseases, for example. The idea that the seat of pain is in the cortex has not been substantiated, for when a cortex is irritated there is locally only an hallucination of pain; the real pain is exhibited on some part of the body. Then if the attack of cephalalgia is not due to local irritation of the cortex, the seat of the trouble must be in the meninges. It is to dilatation of the vessels of the meninges, causing intracranial pressure, that the pain is due. The vascular dilatation extends to the minute blood vessels in the region of the pituitary body, rupture of which gives rise to the epistaxis from which patients so frequently suffer during an attack of headache. It is clear how this explanation answers for hyperæmic conditions, but how does it account for the same symptoms in anæmia? In anæmia there is a qualitative and not a quantitative change in the blood, the amount of fluid in the vessels remaining the same. In veritable anæmia from excessive depletion of the system, as from hæmorrhage or cholera the condition is different; but from the anæmia coincident with neurasthenia, hysteria chlorosis, and so forth, there is, so far as quantity is concerned, the same condition as in hyperæmia.

In anæmia the vessels are very prone to dilatation, producing an exaggeration of the intracranial pressure, in consequence of overexcitability of the vaso-motor centers allowing of local hyperæmias.

The author definitely states that the seat of pain in headache is always in the dura mater and not in the cortex; that the pain is provoked by the compression of the dura mater produced by increased intracranial pressure; and that this is true of all headaches, whether neuroses, or of toxic or mechanical origin—such as diseases of the brain or of the meninges, constipation, etc., or of reflex origin.—*N. Y. Med. Journal.*

### The Treatment of Sprains.

I divide sprains into three degrees, viz., a mild sprain, a severe sprain, and a sprain of a still severer character. The treatment I would advise for a mild sprain would be the use of hot water and massage by means of vaseline. For a more severe degree of sprain I would apply the same treatment, plus Martin's rubber bandage, and urge the patient to walk about; and for the third degree of sprain I would use hot water as before, and a plaster-of-Paris splint, which should not be applied until twenty-four hours after the injury.—*Internat. Jour. of Surg.*

### Lubricant for Catheters.

Castor oil is an excellent material for this purpose. It is non-irritating and tenacious. It should always be applied warm, and the bottle containing it should be frequently washed with alcohol. It can be used for silk and rubber catheters alike.—*Dr. J. M. Kitchen.*

### Antipyretic Drugs.

Dr. N. S. Davis (*Med. Age*) declares that antipyretic drugs are of value only as nervous sedative! He considers cold the best of all remedies for the reduction of temperature.

## SURGERY.

### A New Treatment of Mammary Abscess.

Tweedy (*Medical Press and Circular*) adopts Weber's method of treating mammary abscess.

An early and free incision is made in the breast, radiating from the nipple, and situated at the most dependent part of the abscess.

The finger is then inserted into the wound and the gland structure broken down. This manipulation, it is stated, will have no bad effect on the healthy tissue.

By this process several new cavities will be found, and these, in turn, are to be opened by an incision similar to the first, and the whole thoroughly douched with some antiseptic solution.

The membrane lining the several cavities is to be curretted, and the *debris* removed by a second douching.

Strips of gauze sufficient to fill every interstice of the abscess are to be steeped in a one per cent. solution of carbolic acid, and inserted by means of a long sinus forceps and probe. A large, flat sponge is then placed on the breast and tightly bandaged thereto for twenty-four hours. After this period the dressings are removed, and without further irrigation the cavities are again packed, the sponge and bandage being reapplied as before.

On the third day the process is repeated.

In the fourth dressing the gauze packing is dispensed with and the incisions are drawn together and dressed antiseptically; the sponge and bandage are reapplied.

This last process is repeated every twenty-four hours until healing is complete; this usually takes place about the tenth day. In one of the author's cases the whole process was accomplished without the aid of anæsthesia. In only one of his cases was it necessary to make a second incision. The incisions are never longer than is necessary to admit a finger.

Iodoform gauze should be used for packing the wounds.

The author only having treated five cases, cannot say definitely what portion of the above treatment is essential, but he is strongly inclined to the opinion that curetting can be safely dispensed with.

### Intubation.

In regard to the comparative merits of intubation and tracheotomy as life-saving measures in the treatment of croup, I do not know of any stronger argument that could be produced in favor of the new procedure than a short quotation from a paper by Dr. L. S. Pilcher, of Brooklyn, during a discussion on this subject before the Kings County Medical Society (*Brooklyn Medical Journal*, August, 1893).

Dr. Pilcher, while advocating the claims of tracheotomy as the greater life-saving operation, makes the following very candid statement: "I believe that it has been my lot to be called upon to do tracheotomy for the relief of croup in a considerable proportion of the cases that have sought surgical relief, and yet during the seventeen years which I have been operating I have been called upon to do the operation but 66 times, notwithstanding the deaths from croup in our city during this period amounted to between 400 and 500 every year. On the other hand, during the past four years Dr. McNaughton has been called upon to intubate 142 times. He has been instrumental in saving 42 lives in four years, I but 22 in seventeen years, notwithstanding 33.33 per cent. of my cases recovered and but 29.5 of his." In other words, Dr. Pilcher was doing tracheotomy on an average of four times in a year, when the deaths from croup during the same period amounted to between 400 and 500.—O. Dwyer, in *N. Y. Med. Journal*, March 10, 1894.

### Pruritis Vulvæ.

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|---|---|
| Potassium bromide | 2 parts. |
| Lupulin | 2 parts. |
| Hydrargyri subchlor | 10 parts. |
| Olive oil | 30 parts. |

To be used as an external application.

—*Prov. Med. Jour.*

### Cough.

In severe paroxysms of coughing from whatever cause, a tablespoonful of glycerine in hot milk or cream will give speedy relief.

### Treatment of Hydrocele.

Dr. J. Neumann employs the following method, which he claims is less painful, and less likely to be followed by inflammation than other operations, and effects a cure within a shorter time. After the parts have been cleansed and rendered antiseptic, he punctures the scrotum with an ordinary trocar, withdraws the stillette, and as soon as the fluid flows out, pushes the cannula further up and leaves it *in situ* for two days, holding it in place with a cotton dressing and bandage. After removal of the cannula the swelling and redness of the skin is subdued by cooling lotions, such as led water. The author has tried this procedure in six cases, and was able to obtain obliteration of the sac without the occurrence of inflammation or suppuration.—*Int Jour. Surgery.*

### Gold Chloride in Pill-Form.

Dr. P. Carles advises administering gold chloride in the following excipient:

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|---|---|
| Calcined kaolin | 2 parts. |
| Calcined sodium sulphate | 1 part. |
| Water | 1 part. |

In spite of their hardness these pills are very soluble and retain their constituents unaltered.

### Bismuth in Gastric Disease.

Matthes (*Centralbl. f. inn. Med.*) has investigated, both experimentally and clinically, Fleiner's method of treating irritative diseases of the stomach with large doses of bismuth. The results of the treatment were very successful, especially in lessening pain. From experiments on dogs, the author shows that ten to twenty minutes after ingestion the bismuth sinks to the lowest part of the stomach, whereas several hours later it is found spread over and fixed to the stomach wall, being intimately mixed with mucus. Even with a full stomach a large part is also found similarly deposited. Against the action of chemical agents on the stomach wall this deposit of bismuth is most resistant. In men shortly after the ingestion of bismuth, the water used for washing out the stomach returns clear, but if later the stomach contents be expressed, bismuth with mucus is removed. Experimentally bismuth is shown to increase the secretion of mucus. To determine the action of bismuth in cases of erosion, etc., of the stomach, defects were made experimentally in dogs in the stomach mucous membrane and bismuth was then administered. In some experiments nothing particular in regard to the defect could be made out. In two experiments, however, positive results were obtained. In one an adherent crust was found acting as a protection to the defect. Sections taken from both cases showed healing ulcers. In the case of the crust, crystals were found in the granulation tissue, and proved both morphologically and by a color test to be bismuth crystals. No symptoms of bismuth poisoning occurred. Experiments thus show that bismuth adheres to the defect in the stomach wall, and that healing may take place under a crust so formed. This crust is not always found, but its occurrence once shows the possibility of it. Comparison with control animals showed that in those treated with bismuth the defects healed more rapidly. Digestion can go on while the bismuth deposit is present. If an artificial digestion, however, be shaken up with bismuth, pepsin will be carried down by the bismuth and digestion is thus hindered. The author says that both experimentally and clinically Fleiner's method of treatment is practically and theoretically correct with the exception of the question of position (in reference to the site of the ulcer), which he shows to have no influence in regard to the subsequent deposition of the bismuth.—*Provincial Medical Journal.*

## PATHOLOGY.

### Etiology of Appendicitis.

Hodenpyl (*N. Y. Med. Jour.*) holds that there are two classes of factors in the causation of acute appendicitis: predisposing, which may vary in different cases; and more active factors, of which there seem to be two distinct, but intimately associated elements: (*a*) bacterial, of which the bacillus coli communis is very probably the most important; and (*b*) the less well-defined and less understood chemical factors associated with the fæcal contents of the intestines. Of the predisposing causes of acute exudative appendicitis, stricture of the appendix is one of the most frequent. This condition though sometimes probably the result of previous inflammatory processes, is, in a large proportion of instances, the result of partial retrograde evolution, the cæcal opening, which is much dilated in the infant, gradually contracting until adult age, when it is smaller than the rest of the lumen, and sometimes much constricted. The vermiform process, like other organs which undergo retrograde evolution, is very prone to become inflamed. Again, the longer the appendix the more liable it becomes to inflammatory changes. Other predisposing causes are adhesions drawing the appendix into abnormal positions, atrophy of the mucous membrane, and concretions. The last-mentioned cause, though formerly regarded as the usual one, does not exist in more than 10 per cent. of the cases of appendicitis. The author, though led at one time by the results of his own investigations to regard the bacillus coli communis as a most important factor in the causation of acute appendicitis, acknowledges that the recent observations of Barbacci have proved the necessity of caution in attributing a too exclusive *role* to this bacterium. Barbacci has shown that perforative peritonitis is not due to the introduction of the bacillus coli communis alone, but is the result of (1) the escape of fæces and intestinal gases into the peritoneal cavity; (2) the development of other forms of bacteria therein; and of (3) the constant irritation arising from the continued escape of intestinal contents.—*British Medical Journal.*

### For Myalgia.

For the relief of myalgia the *Practitioner* prescribes :

℞ Linimenti chloroformi,
Linimenti aconiti ..... .....āā f ʒ ss.
Tinct. opii.... ..... f ʒ iij.
Liniment saponis.....q, s ad f ʒ iv.

M. Sig. To be well rubbed into the painful parts.

### Nitro-Glycerine in Sciatica.

Dr. Lawrence (*Rovista de Ciencias Medicas de Barcelona*) reports the case of a carpenter of fifty-two years, who suffered for several years with sciatica. In order to alleviate the pain, he had become a morphine user, and could not abandon the habit. After trying a multitude of drugs, he gave him a 1.100 solution of nitro-glycerine, one drop three times a day, gradually increasing the dose to five drops. Relief was almost immediate, and in ten days he could resume his work, completely cured.—*Lancet-Clinic.*

## ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM APRIL 29, 1894,. to MAY 5, 1894.

Paragraph 2, S. O. No. 86, April 12, 1894, A. G. O., assigning First Lieut. Harlan E. McVay, Assistant Surgeon, to station at Angel Island, California, is revoked. He will be relieved from duty at Fort Huachuca, Arizona, and will report for duty at the Presidio of San Francisco, Cal., relieving First Lieutenant Charles Willcox, Assistant Surgeon, who after being thus relieved will report for duty at Angel Island, California.

First Lieutenant John S. Kulp, Assistant Surgeon, is relieved from duty at Fort Sheridan, Illinois, and ordered to Fort Spokane, Washington, for duty.

First Lieutenant George M. Wells, Assistant Surgeon, will proceed to Fort Bowie, A. T., and report for temporary duty, not later than the 15th instant, during the absence on leave of Captain Jefferson D. Poindexter, Assistant Surgeon.

Leave of absence for two months, to take effect on or about May 1, 1894, with permission to go beyond sea, is granted Major Calvin DeWitt, Surgeon.

Captain C. N. Berkeley Macauley, Assistant Surgeon, is relieved from duty at the U. S. Military Academy, West Point, New York, and ordered to duty at Fort Wingate, N. M., relieving Major Washington Matthews, Surgeon, who on being relieved will repair to Washington, D. C., and report in person to the Surgeon-General for temporary duty in his office.

So much of Paragraph 13, S. O. 79, A. G. O., April 3, 1894, as assigns Major Peter J. A. Cleary, Surgeon, to duty at Fort Wingate, New Mexico, is revoked.

Leave of absence for two months, on surgeon's certificate of disability, to take effect when his services can be spared, with permission to leave the Department of the Colorado, is granted Captain Edward Everts, Assistant Surgeon.

## NEWS AND MISCELLANY.

### Mutter Lectureship of the College of Physicians of Philadelphia.

The next course of ten lectures, under the bequest of the late Thomas Dent Mutter, M.D., LL.D., "on some point or points connected with Surgical Pathology," will be delivered in the winter of 1896–97 before the College of Physicions of Philadelphia. Compensation, $600. The appointment is open to the profession at large. Applications, stating subjects of proposed lectures, must be made before July 1st, 1894, to

WILLIAM HUNT, M.D.,
*Chairman of the Committee on the Mutter Museum.*
S.E. cor. 13th & Locust Sts., Philada.

THE
MEDICAL AND SURGICAL
REPORTER.

No. 1943. PHILADELPHIA, MAY 26, 1894. Vol. LXX—No. 21

## ORIGINAL ARTICLES.

### SUMMER DIARRHŒA IN CHILDREN.

C. F. CAMP, M. D., Barre, Vt.

No department of medicine requires more thorough study and constant attention than this. How quickly, if the least opportunity offers, our patient slips away. No disease removes more children from our midst. Scarlatina may sweep away more in a given epidemic, but it is not so constant. When the epidemic passes it seldom occurs again in the same locality for years; whilst every summer brings with its hot and sultry days of July, diarrhœa which often remains with us until October.

Depending upon no special contagion for its prevalence; relying upon no previous attack for immunity against another even the same summer, it is more to be dreaded, both from its insidiousness and constancy. No country, town or locality escapes it, indeed, hardly an individual escapes its sudden attacks, though the very old or young are the only ones in which fears are entertained as to consequences. What other disease is there that knows no bounds, owns every locality, claims so many victims each year and is given so little attention?

No disease has a greater multiplicity of exciting causes. Atmospheric changes, errors in diet, exposure, confinement to house, in fact, we might say any change favors its development.

Too little stress is laid upon this condition. Mother's are led to think the child's case needs but little attention other than care from exposure or change in diet. This may be good treatment at the hands of a physician but, as a rule, for mother's to follow alone, unaided by other advice—as an idea for physicians to advance to the laity—it is dangerous.

I do not wish to be thought an alarmist in this direction, nor would I have you say to every mother that her child has cholera infantum for the purpose of making a remarkable cure, or shield yourself in case of neglect or oversight.

I am constrained to think the larger portion of cases are the results of errors in diet, *i. e.*, in the younger class of patients. A complicated feeding-bottle is a very dangerous thing in the hands of a nursing infant. A common four-ounce bottle of the shops, armed with a small, black rubber nipple is the best suited as a substitute for a mother's breast. The nurse should wash it thoroughly every time used. In the use of this size bottle, the danger of over-feeding is lessened; the food is brought fresh every time and the habit of having a large, half-filled bottle lying in the carriage or a cradle is obviated.

Many babies are overfed, yet if they cry of stomach-ache they get another meal. After a few days of this there comes the resulting hyperemia, indigestion, catarrh, diarrhœa (summer or otherwise)—cholera infantum. It often depends upon the attending physician as to which of these diseases is applied to the poor sufferer, and often it makes no difference, the result is for the bad. Many times if the bottle, the great exciting cause, were removed, the result would be a complete cure without other treatment.

A few cases are predisposed to catarrhal disorders, and their ills will be catarrhal in nature. Fewer still there are, yet they do exist, who are affected through the nervous system, either directly or sympathetically, and when undue excitement or nervous strain is brought to bear, the bowels are the first organs to give warning.

The child with thin features, large eyes, long neck, pale flabby skin presenting a bluish tinge, predisposed to glandular diseases; one with a scrofular habit, is particularly susceptible to diarrhœa.

The subject of treatment is the all-absorbing thought. We know the cause, locations, and all else; but if unable to cure, we might as well be ignorant of all.

There is much confusion and contradiction in the journals as to the treatment of this disease. In almost every State, county, or town, there is difference in treatment. Indeed, every physician has his own specific or pet fad, and all is so susceptible to change, that one following would have to change every day. This, together with the food of proprietary medicines and foods constantly advertised in the journals, left at your office, with the recommendations of college professors appended, makes the chances of the patient exceedingly hazardous, if used.

I have often thought that in our eagerness to accomplish the very earliest cure, we too often depart from the old, rational line of reasoning in our chase after rainbow specifies, hence in my treatment, I shall endeavor to prescribe in a fashion that can be reasonably defended.

First, we see those, most of all, who are merely suffering from laxness. The secretion seems healthy enough, yet the excretion is thin and frequent—no pain—no weakness, leastwise not for many days. In these cases some mild astringent, combined with tonics, will be sufficient, as bismuth and nux vomica.

I think next frequently, and perhaps most so, we find the diarrhœa of indigestion, gastric, intestinal or otherwise. To this you can give your best and every thought, and often with small success.

In this form we find the greatest number of changes in the stools; all colors and shades. In correcting this condition success lies in the ability of the attending physician to determine the locality of the indigestion. If it be in the stomach, pepsin will do much for the relief; but very little benefit will be derived if the indigestion occurs below the stomach.

The liver, if torpid, may be improved by small doses of *mercurius vivus,* (which I like much better than chalk mixture, as it does not deteriorate). Should the liver be very active with a hyper-secretion of all the organs, resulting in copious discharges, green in color, much good is obtained in the use of the rhubarb mixtures. I have used Rhus, Soda and Peppermint; Rhus, Soda, Peppermint, and Opium. When pain was severe in the older patients, a mixture: Rhei tr., Opii tr., Menth. pip. ess., Camphor Spirits, gives best general satisfaction.

The least frequent, and most dangerous to our patients, is cholera morbus, or cholera infantum, with its attending vomiting, pain, diarrhœa, collapse,—death! This, if we treat with any success, must be treated early and understandingly.

What is the lesion? Every secretion seems impaired. The alimentary canal is a veritable sewer into which the liquids of the body are poured, altered, acrid, putrid, almost rice-water discharges, anything but normal. Here we have the chance for the utmost energy. I believe alteratives are here of the greatest benefit to correct these changed secretions. I have used with much success:

℞ Hydrag. bin. iod..... 1-160 grain.
Potass. iod..... 1-60 grain.

This is an alterative of great value, especially when the discharges are watery and light in color.

Arsenite of copper is very valuable in this connection. Camphor alone or combined with opium is of great service when there is a threatened collapse. Tonics and stimulants are indispensable. I am partial to Catawba Wine for children's diseases; think it superior to the cereal liquors.

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Imp—Well did you get into the Garden of Eden?

Satan—Yes; I took the form of a serpent and finished up the business in short order.

Imp—How did you induce the woman to risk everlasting torment for just one mean little apple?

Satan—I told her it was good for the complexion.—*Life.*

# HYDROPHOBIA.

HIRAM CORSON, M. D., PLYMOUTH MEETING, PA.

[CONTINUED FROM PAGE 705.]

## HAVE CASES OF HYDROPHOBIA BEEN CURED?

In the Encyclopedia already spoken of and published more than a century ago, the author gives many reputed cures and preventives, every one of which was highly lauded in its day, but only two cases were reported as cured after the paroxysms commenced, and they were cases which, judged by the account of them, might now properly be placed in the pseudo-hydrophobia list.

In 1753, a woman with hydrophobia in consequence of a bite from a dog supposed to be rabid, was blooded to about fifteen ounces on Saturday, and given a two-grain pill of opium every two hours. On Sunday the pill, with sulphate morphia added, having been continued, she was bled twenty ounces. On Monday her swallowing was better and the opium and morphia continued, and twelve ounces of blood taken. By a continuance of remedies she recovered. (Page 277.) This case brought opium into great repute, giving no credit to the blood letting. Both of those means were heroically used after that time for many years, but were finally proved to be of little value.

About the same time, 1753, Dessault, by a cure attributed to mercury, gave that remedy great repute. It was given internally and by rubbing mercurial ointment on the sore and on the arm of that side. It is much used and relied on, but time rolled on and the use of mercury was found to be as inefficient as the other vaunted means.

It is very interesting to read of the heroic efforts which were used with every new medicine or physical means that were spoken of as being efficient to cure. Cold baths are much relied on, and patients were carried to rivers and not only dipped in, but kept in for long times, and held under, sometimes until almost drowned. Arsenic too, was extensively used as well as every quack remedy that had any repute. But all failed to hold the confidence of the physicians and the public.

And so from that time until the present, the treatment has been in the hands of non-professional people who have their vaunted remedies. The Fry's, Stoy's, Emery's and Vansciver's, and the mad-stone people have the confidence of the people, and physicians are ignored, as they deserve to be, in having confessed to an inability to cure a malady which they have never investigated as they should have done.

## IS THERE A PREVENTIVE OR CURE FOR THIS DISEASE?

The experience of two thousand years has proven beyond a doubt to every person who has studied the history of hydrophobia, that cleansing the wound thoroughly with caustic, or even incising it without caustic being afterwards applied, is a perfect preventive against rabies. No, not every person now. People who have institutes, like Pasteur in Paris, Gibier in New York, and C. N. Hewitt at Red Wing, to cure or rather prevent rabies in human beings, and who advertise the world over for persons to come to them, have seen that it is important to go back on their former, strong belief in the preventive means so long successful; so successful indeed that the great veterinary surgeon, Youatt, declared emphatically that the means spoken of, if done at any time previous to the actual development of the disease, would, if properly used, be successful in preventing further trouble. Yes, they not only declare these means not only useless, but ofttimes injurious. What motive inspires them? I need not say—a word to the wise is sufficient. Their acts speak as loud as their words. Despite their boasts Fry, Stoy, Emery and the mad-stone can all show greater success.

## ELECAMPANE AS A PREVENTIVE AND CURE.

Judge Richard Watson, after reading my pamphlet on hydrophobia, wrote to me as follows: "Are not many physical diseases brought about or greatly aggravated by mere mental fear or excitement? Your essay seems to point to this in hydrophobia. I remember hearing when a child that elecampane was a cure, or a preven-

tive of hydrophobia. My father had a favorite slut bitten by a rabid dog—he also bit some cattle that were said to have gone mad. The slut was kept chained for about a year and fed on elecampane and milk, then she was loosed and lived to die of old age. I thought it was an imprudent risk, but it showed their confidence in the medicine."

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THE "OLD CHESTER VALLEY CURE" *

*From *Our Dumb Animals*, Boston, July, 1874.

A lady met me this morning, saying "Did you see that receipt in yesterday's paper for curing hydrophobia?" I had not seen it. "Well," she continued, "it is just the cure I wanted you to write about two or three years ago—the Old Chester Valley Cure."

I remember perfectly her anxiety that I should write to the public and proclaim that elecampane and fresh milk is the specific for hydrophobia, and my purpose is to repeat the account she gave me of it.

In her old home in Chester county, Pennsylvania, lived a German named Joseph Emery, who used to be sent for far and wide, when anyone had been bitten by a rabid animal. He went to see his patient carrying something understood to be a root, which he himself dug in the woods. He took a pint of fresh milk from the cow, put his root into it, boiled it, gave it to the patient fasting; made him fast after taking it: gave a second and third dose on alternate days and never failed in effecting a cure. In some way which she had forgotten, his secret transpired and the root was know to be elecampane. So well did he establish the local reputation of his specific, that, in his neighborhood, folks were not afraid of mad dogs.

The intelligence and integrity of my informant are beyond question, and I regret that her love of privacy should prevent her from giving the weight of her name to her conviction that this is an unfailing specific for hydrophobia. The people of Chester county are not a class likely to be misled by superstition, and she is confident that it was a general or universal belief that Joseph Emery never failed to cure or prevent hydrophobia. In one case the spasms had begun before the first dose was given, and the patient recovered. The medical properties of celeampane are very powerful. Milk itself is a specific for many poisons, and while the medical faculty know no cure for this terrible disease, we should open every avenue of light to the dark subject. If the disease is one of the imagination, we want a specific to give confidence and cure by the imagination; but this looks like a real cure of a veritable disease.—Jane Grey Swisshelm, in *Pittsbury Commercial.*

Robert Shoemaker, for a long time the experienced head of a wholesale drug house in Philadelphia, has been for about twenty years a strong believer in the protective power of elecampane as a preventive of rabies and has written much on the subject. I quote an article of his published in the *Philadelphia Ledger* years ago. "My attention was drawn to elecampane many years since as a preventive of hydrophobia. The active medical principle of the plant is found in the root and is called *inulin.* This I believe neutralizes the virus. Allow me to give a few instances, where this simple remedy has been used. My nephew, then a small boy, was badly bitten in the face by a dog unmistakably mad. The father of the lad came immediately to the city for advice. We called on an eminent physician, who at once prescribed the plant named. The root was given as hereinafter directed. No symptoms of hydrophobia appeared and the lad, now a hale, hearty farmer, lives to show the scar of the wound in his face." The physician above referred to, related to me a number of instances in which the remedy had been used and *always with success.* He, in fact, remarked, 'I never knew it to fail when properly administered.' I will give you but two cases:

"*First*, Two men living near the city were bitten by the same dog, and within fifteen minutes of each other. The dog was secured and the next day showed unmistakable signs of madness and finally died of hydrophobia. Alarmed for their safety, both men came to the city next day and waited on the physician quoted above. He prescribed elecampane root. One of the men remarked, 'that is an old woman's remedy' and refused to take it. The man returned home and put himself under the care of his own physician, who cauterized the wound and gave him medicine to salivate him. On the ninth day he was seized with spasms and died in

agony. The other man took the elecampane and never suffered in the least degree from the dreaded disease.

"*Second,* A number of cows in pasture were bitten by a mad dog. This coming to the knowledge of those who heard of the elecampane remedy, they thought it a good opportunity to give it a trial. The cows were accordingly separated. To one half the number, the root was administered (in form of decoction) and not one of the cows suffered from hydrophobia; whilst all of them not so treated took the disease and died from its effects, or were shot.

"In quite a number of cases coming under my observation of persons bitten by dogs supposed to be mad, I have recommended the use of the elecampane, and have yet to learn of the first case of hydrophobia resulting from such bite where the root was used. I have, therefore, good reason for confidence in the remedy. Whether after the disease manifests itself it would have a good effect, or any effect at all, I am unable to say. But the antidote is so simple and so readily obtained that it would be almost criminal not to employ it.

"Having said this much allow me to give the mode of using it. To one and one-half ounces of good, sound elecampane root, bruised in a mortar, add one pint of new milk, boil it to half a pint, strain off, and when cold take it at a dose, in the morning, fasting. No food should be taken for three to five hours afterwards. Repeat the dose on the third morning, allowing one morning to intervene, and again on the fifth morning. The above quantity is for an adult. For a child give a proportionate dose, say to one twelve years old, half the quantity."

The editor of the *Ledger* remarked on the above: "It is deemed proper here to express the strong belief that in a great many cases in which hydrophobia symptoms occur, the symptoms are induced by excited imagination and apprehension. Considering the large number of cases of injury from bites of dogs that occur every year and the small number of well authenticated cases reported as hydrophobia, persons who have the misfortune to get bitten may well afford to keep their minds at rest about the matter. Not less than a score of the carriers of the *Ledger* have been bitten by dogs, and some of them several times, but they, having no apprehensions of hydrophobia, have never developed the symptoms of that disease. It is well, nevertheless to have the elecampane ready at hand."

Such is the statement—scores of times these carriers were bitten, but having no dread of a disease from the bite of healthy dogs, they paid no heed to their injuries and yet no harm came to them. But despite the fact that millions of such cases have occurred and no harm resulted, we are now told by Pasteur, Gibier and Hewitt and other pupils of the Pasteur Institute, that there is danger of rabies from the bite of even healthy dogs, and all who are bitten should come to the Institute; travel at great expense, hundreds of miles, many of them, and leave a good fee, besides, with the Institute. Such shameless frightening of the public should call down on the heads of the trio, the scorn and censure of all *honest, sensible* people.

More testimony in favor of elecampane as a remedy. My long-time friend Wm. H. Johnson, ex-Superintendent of the Bucks County Public Schools, thus writes me: "Many years ago when a school-boy, a case occurred in Buckingham township. Samuel Gilbert had seven cattle bitten by a rabid dog. It was near my home. Samuel had heard of the use of elecampane; got it; had the root boiled in milk, and to six of the cattle the dose was given by drenching them. In the seventh the animal was so refractory, that after making a thorough trial, the attempt was abandoned *solely* on account of the difficulty. This one took the disease and died. The other six were never affected by it. This and other similar circumstances coming to the knowledge of my mother, she procured and cultivated it. I am very familiar with it and have great confidence in it. I would, though, as a means of greater security previously use the surgical remedies in conjunction with it."

A physician, a graduate of the University of Pennsylvania, well known to me, who in conjunction with his practice has a large drug store, recently wrote to me as follows, "I have for 36 years been furnishing a mad-dog doctor with one of the ingredients used by him. It is a confection of opium. He administers it in 3 gr. doses; equal to 1-10, or 1-8 gr. of opium. He uses it with chick-weed and I know not what else. The small doses

of opium are to allay nervous excitement and to make the patient comfortable."

In addition to the mad-dog doctors named already, there was in the early part of the nineteenth century a Dr. Van Sciver living at Somerville, New Jersey, who had a far-famed reputation for curing hydrophobia.

### POST-MORTEM APPERANCES IN THE RABID DOG.

These are of a distinctly negative character. There is an absence of specific changes. The membranes of the brain are generally injected to a variable extent. The longitudinal sinus is filled with dark colored blood. Heart and pericardium generally normal. The most important changes are a dark condition of the blood, some œdema of the brain and more or less catarrhal alterations of the mucous membrane, especially of the respiratory and digestive canals, and the striking emaciation of the whole animal. In cattle the morbid appearances are often similar to those of the cattle plague. In that disease, as we had it in this county a few years ago, they resembled those of pleuropneumonia. Now do those post-mortem appearances indicate that during life in man they could possibly produce the terrible sufferings spoken of as the invariably attendant on this disease? No! Far from it. Take away the mental anxiety; the disturbance of the nervous system induced by fear, and the suffering, judged of by the effect of such lesions in other diseases, would be that consequent on them in other cases.

## COMMUNICATIONS.

### EXHIBITION OF A CASE OF AKROMEGALY; WITH REMARKS ON TREATMENT BY DESICCATED THYROID GLAND.*

SOLOMON SOLIS-COHEN, M. D.,† PHILADELPHIA.

This case is brought before the Society in order to exhibit some structural changes not found, or at least not recorded, in every case of akromegaly, and to call attention to the apparently good results of treatment with desiccated thyroid gland.

As full details of the case will be published in the *International Clinics* (in my report of a lecture delivered some time ago to my Polyclinic class), I will be brief in the present instance.

The patient, who is some fifty-two or fifty-three years of age, applied to the Philadelphia Polyclinic about eighteen months ago for relief from an excruciating headache, which had for many months been so intense at times as to prevent his lying down, pressure on the scalp increasing the pain. Attention was at once attracted to the peculiarities of facial structures presented, and further examination demonstrated the characteristic curvature of the back and enlargement of the hands and feet. Photographs of the patient taken twenty years ago and six years ago respectively, bear out his statement that his features have materially altered within the last four years, although the later photogfaph shows the beginning of the change.

He has had to enlarge his hat-band twice, and his shoes twice within three years. The shoes are a little longer but much broader than formerly. The hands are broadened rather than lengthened; the fingers not exactly "sausage-shaped," but thick and clumsy. Distortion of the joints is to be attributed to his occupation, and probably antedates the development of the akromegalic conditions. Part of the coarseness of the skin of the hands may likewise be due to occupation. His hands to-day, however, are smaller than when he first came under treatment, as shown by our tracings and measurements, and also by his statement that a pair of gloves bought "some years" ago, and too small for him last year, can now be worn.

The enlargement and projection of the superciliary ridges, the lateral projection

*Read before the Philadelphia County Medical Society, April 11, 1894.

†Professor of Clinical Medicine and Therapeutics in the Philadelphia Polyclinic, Etc.

of the malar bones, the broadening and deepening of the chin, give the face the characteristic lengthened elliptical outline. The great enlargement of the nose; the thickening and projection of the lips; the heavy folds, deep furrows, and somewhat greasy texture of the skin, especially of the forehead; the stiffening and projection of the auricular cartilages, complete the picture. The lower jaw does not, however, project beyond the upper jaw. The teeth are bad. The tongue is thickened and deeply fissured. The voice is deep and has a monotonous quality, the latter only partly attributable to his "boilermaker's deafness." The laryngeal and tracheal cartilages are almost if not completely ossified. The thyroid gland cannot be demonstrated. The forward thrust of head and neck from curvature of the cervico-dorsal spine throws the clavicles well out from the windpipe, leaving a great hollow just above the sternum. The clavicles are enlarged, the scapulæ are enlarged, the ribs are broadened and apparently in contact, and the costal cartilages seem to be ossified. In consequence, although the narrowing of the chest—an apparent lateral compression—and the percussion phenomena show absence of emphysema, it will be observed that his breathing is scarcely at all thoracic. There is an almost inappreciable rise and fall of the clavicles, showing slight vertical motion of the thorax as a whole, and on great inspiratory and expiratory exertion an expansion of one-half to one centimetre can be determined at the nipple line. Breathing is almost exclusively abdominal. This shows, as did my previous case, and some cases of Dr. Dercum's and others, that the disease involves the bones of the thorax as well as those of the extremities.

Our patient is becoming feeble; his muscles are wasting, though as yet electric examination shows only quantitative change.

He has vasomotor phenomena—flushing, occasional vertigo, and polyuria. The urine has been deficient in solids, but has not contained sugar or albumen. We have not, indeed, demonstrated anything abnormal in it. This I attribute, however, to defective methods of examination. I have no doubt that careful chemical analyses will show in the urine the results of altered metabolism. Since treatment with thyroid-powder was instituted the quantity of urinary water has decreased and the urea-content has risen. Ordinarily the thyroid preparation increases both water and solids. Superficially the diminution of polyuria by a diuretic would seem to be an illustration of the so-called "homœopathic law." A moment's reflection, however, shows the action to be simply a correction of disordered metabolism, through which the production of toxins giving rise to polyuria is diminished. Another result of the administration of the thyroid-powder has been to completely relieve the distressing headache.

At one time, after a long absence from the clinic, he returned complaining of violent sciatic pain. It failed to yield to ordinary measures, but disappeared after recourse to thyroid medication. Five grains of the preparation of desiccated sheep's thyroid exhibited by me to the Society last year was given in capsule every morning.

Upon the somnolence, however, no effect has been obtained. The patient can still go to sleep upon the slightest provocation—indeed, without any. He falls asleep while waiting his turn at the dispensary, and frequently missed appointments through sleeping in his chair over the time set. He says that he can keep awake, however, while at work; but as he can no longer do the hard work to which he has been accustomed, he has not for some time had steady employment.

Dr. Jackson examined his eyes, and found no lesion of the fundus and no error in the visual field. This goes to confirm the view that hemiopia and other visual errors are merely secondary phenomena, due to pituitary enlargement, and that the latter is not necessarily a feature of the pathologic complexus. I am, indeed, inclined to believe that early treatment with thyroid preparations will entirely prevent overgrowth of the pituitary body, embryologic analogy seeming to indicate that it is an attempt at compensatory hypertropy, ill-directed and baneful only by reason of the altered position of the structure.

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A CAR driver in Sheobygan, Mich., has been discharged because it was discovered that she was a woman. The gender is a little perplexing.—*Philadelphia Ledger.*

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IF a man would live in peace, he should be blind, deaf, and dumb.—*Ex.*

# ACUTE PUERPERAL CELLULITIS AND TRUE PELVIS ABSCESS.*

CHARLES P. NOBLE, M. D., PHILADELPHIA.

It is my purpose in this communication to report my experience with acute puerperal cellulitis and true pelvic abscess, collecting together in one paper the various cases which I have reported from time to time. The time has now come when such a communication will be received in a proper spirit—that is, as a report of conditions carefully observed at the bedside, and therefore as a contribution to scientific medicine. The first whirl of excitement which followed the discovery of the real nature of chronic pelvic inflammatory troubles has passed by. Men are no longer blinded by the prejudices of the era when all pelvic inflammation was regarded as cellulitis. A sufficient time has now elapsed to enable them to recover from the reactionary wave, during the height of which it was believed that all pelvic inflammation was necessarily tubal in origin. Practitioners of medicine are very prone to be ruled by the dogmas of a few leaders in professional thought, and gynæcologists are no exception to this rule. During two generations they gave implicit adherence to the dogma of Nonat, Churchill, and Emmet, and during the present generation no less implicit adherence to that of Tait and his disciples. It is now time to accept all the facts in the case whether or not they agree with prevailing theories.

CASE I.—This patient I saw operated upon May 8, 1888, by Dr. D. Longaker, who gave me the following history: Mrs. F., aged twenty-six years, III-para. She was delivered of the third child seven weeks ago, by a natural and easy labor. On the fifth day she had a chill, and chills and fever continued thereafter, also great pain. Dr. Longaker saw her seven weeks after labor, and operated for a clearly defined mass situated mostly in the left side of the pelvis, rising up above the brim of the pelvis and extending from the symphysis pubis to the iliac crest. An exploratory cœliotomy showed that both uterine appendages were of normal size, but were somewhat fixed by recent adhesions; "neither right nor left ovary nor tube formed any part of the mass; these structures could be distinctly outlined apart from it." Fluctuation was distinct in the swelling as made out by the intra-abdominal finger. A second incision was made above Poupart's ligament, and about half a pint of pus was discharged. The pus cavity was located in the left broad ligament, and extended between the uterus and bladder into the right broad ligament. The patient made a good recovery, but has borne no children since. This is probably because effectual means were taken thereafter to prevent conception.

CASE II.—This patient was seen at the Philadelphia Lying-in Charity during my service there as senior assistant physician. I am unable to find any published notes of the case. My recollection of its salient points is very clear and distinct. This patient was infected after labor, and after a number of days presented the usual evidences of suppuration, together with the signs of intense inflammation on the right side of the pelvis and in the right inguinal region. A hard mass of exudate formed in the right groin, which could be distinctly outlined by palpation. There was every evidence that this was a case of true pelvic abscess, but influenced by the teaching that all pelvic suppuration is intra-peritoneal, an abdominal section was made by Dr. Charles Meigs Wilson, assisted by myself. The uterine appendages were carefully examined, and it was evident that the pus accumulation was entirely distinct from them, and that it was external to the peritoneum. The abdominal incision was closed and the pus let out by an incision made above Poupart's ligament, near the anterior superior spine of the ilium. The patient made an uninterrupted and quick recovery.

CASE III.—This case I saw in consultation with Dr. Himmelwright, March 2, 1890. The history, as given to me by Dr. Himmelwrigt, is as follows: The patient had a miscarriage, January 3d, in the second month of pregnancy. One week later, symptoms of pelvic inflammation appeared, and a diagnosis of peritonitis was made. The patient got about by February 1st. After a week, pain was

* Read before Philadelphia County Medical Society, April 11, 1894.

felt in the right inguinal region, and gradually increased in intensity, extending to the lumbar region. After another week (February 15th) she was unable to walk erect and to put her foot firmly on the ground, but had to stoop forward. During this time the temperature remained normal and there were no chills. At times the pulse was slightly accelerated. The pain continued to increase, and, on February 27th, a swelling was noticed in the right lumbar region. March 1st, the temperature rose to 101° F., and the pulse to 120, and there were slight chills. March 2d, I saw her. The temperature was normal, the pulse about 90. The right inguinal region was tender, suggesting, indeed, appendicitis, but there were no symptoms to warrant the supposition. A semi-fluctuant swelling was found in the right lumbar region. The next day this swelling had increased, and a hard mass was felt in the right inguinal region, extending as high as the ribs. The swelling in the lumbar region was opened and two or three pints of pus escaped. Introducing my index finger, it passed around the ilium into the iliac fossa. A rubber drainage tube was introduced, and irrigated daily with a dilute solution of peroxide of hydrogen. This discharge gradually decreased and the tract rapidly healed, closing from the bottom.

It may be asked: "Why is this claimed as a case of true pelvic abscess?" The abscess was undoubtedly situated in the false pelvis on the right side. I had my finger in it. The entire absence of bowel symptoms excludes perityphlitis. The fact that, on examination, the uterus was found movable and the broad ligaments free from exudate—no fixation of the appendages—excludes pyosalpinx. Hence I take it, the abscess was due to the breaking down of an infected pelvic gland situated behind the peritoneum, in the right iliac region.

Case IV.—This case was in every way similar to the first. I saw the patient in consultation with Dr. Langrehr, five weeks after labor. The perineum had been torn, and was sutured some hours after labor. Septic infection occurred, and for three weeks the temperature ranged between 100° F. and 103° F. During this time there was no pain or distention of the abdomen, or tenderness of the uterine appendages on examination. The perineal wound became inflamed, however, and the stitches were removed. During the fourth week all the symptoms abated. At the beginning of the fifth week the fever increased and tenderness in the left inguinal region became marked. Purulent matter had been discharged *per vaginam*, but whether or not it came from the abscess which had formed was questionable. On examining the patient five weeks after labor, I found her much depressed, in a typhoid condition, with a swelling above the pubes and to the left. Under chloroform a mass of exudate was felt in the left broad ligament extending between the uterus and the bladder, and plainly palpable above the pubes. My diagnosis was true pelvic abscess. I advised median section for an absolute exclusion of complicating pyosalpinx; then a second incision parellel with Poupart's ligament, to evacuate the abscess. This was done by Dr. Langrehr on the following day. The uterus, ovaries, and tubes were found healthy. The omentum was, in places, densely adherent. The abscess was situated within the broad ligament, and extended upward behind and two inches above the ramus of the pubes. It contained about six ounces of thick pus, which was evacuated by an incision in the left inguinal region, directly above Poupart's ligament. The ultimate recovery was perfect.*

Case V.†—Mrs. G., aged thirty years, II-para, was delivered January 18, 1893, of a living child, after a normal labor. The placenta was delivered by the introduction of the hand. The following day Mrs. G. had a temperature of 104° F., and was suffering much from pain in the right groin and from tympany. On the night of the 20th, I saw her in consultation. The temperature was 103° F., the pulse 110, and there was marked tympany and much tenderness in the right groin. A striking feature in the case was that, although the bowels were very much distended, the abdominal wall itself was not very tense. The coils of distended bowels could be very plainly observed through the abdominal wall. The bowels had not been moved for four or five days. The patient was put upon quinine, strychnine, and digitalis, and the bowels were freely moved. Vaginal and intra-uterine douches

* The first four cases have been reported in the *Medical News* of August 29, 1891.

† Annals of Gynæcology and Pædiatry, June, 1893.

of corrosive sublimate were employed, although the lochial flow was not foul-smelling. The patient's condition remained very much the same until the seventh day, when the right broad ligament became infiltrated, so much so as to be plainly palpable above the brim of the pelvis in the right groin, while from below the anterior and right quarter of the pelvis was filled with exudate closely attached to the pelvic wall and displacing the cervix backward into the hollow of the sacrum. This exudate began to disappear about the fourteenth day, and was absorbed very rapidly. Convalescence was further interrupted by a nephritis, possibly of septic origin, and also by severe intestinal pain accompanied by diarrhœa, presumably due to inflammation of the large bowel. This patient was seen in consultation by Drs. Goodell and Parish. She eventually made a good recovery.

Case VI.—Mrs. H., aged twenty-eight years, II-para, was delivered of her second child in March, 1891, the labor being conducted by a midwife. She was infected and was extremely ill. I saw her with Dr. Leopold five weeks after the labor. At that time she was prostrated, with a rapid pulse, "leaky" skin, chills, irregular temperature—in fact, the classical symptoms of septic intoxication.

On examination the right broad ligament was found indurated and a mass of exudate extending on the right side of the abdomen almost as high as the umbilicus. From the extent of the *mass* it was supposed that a right pyosalpinx with an intraperitoneal abscess existed; but in view of the puerperal history and the existence of a cervical laceration the possibility of a true pelvic abscess was discussed. A median abdominal incision was made April 16th, and the abdominal viscera in the lower right quarter of the pelvis was found fused by adhesions. The patient took ether so badly, becoming cyanosed while still partly conscious, and the pulse was so weak, that I and the gentleman present were convinced that to attempt the separation of the adhesions, and the evacuation of the pus from above, would result in her death on the table from ether. An unsuccessful attempt was made to reach the pus by an incision made near the anterior superior spine of the ilium without giving more ether. The exploration was not pushed, owing to the patient's bad condition. The patient was then put to bed and improved for some days. Operation was again proposed and chloroform selected as the anæsthetic, which produced as much cyanosis as ether had done. An incision was now made directly over the broad ligament, the uterus was located, and the index finger was forced into the broad ligament, evacuating several ounces of pus. With rubber drainage a satisfactory convalescence followed.

October 27, 1892, I operated on Mrs. H. to cure a ventral hernia which had formed at the site of the third incision. On opening the abdomen I was surprised to find that the adhesions throughout the right side of the abdomen, which had been universal eighteen months before, had disappeared, except a point of adhesion between the omentum and hernial sac, and another between the omentum and broad ligament. Both appendages were perfectly healthy. This fact demonstrates what was believed when the pus was evacuated, namely, that it was not a pyosalpinx, but an abscess of the broad ligament.

The disappearance of the very extensive adhesions in this case is worthy of record as showing that peritoneal adhesions are not necessarily permanent.

It is of interest to report that during the summer of 1893 this patient was delivered of a living child after normal labor, and that she is at present in good health.*

Case VII.—Mrs. F., aged eighteen years, was confined May 8, 1893. She had a mild puerperal sepsis and was in bed for two weeks. The following month she was constantly sick, being in and out of bed, suffering with pelvic pain, anorexia, and having more or less fever. (The temperature and pulse I do not know, as I was not in attendance.) She came under my care six weeks after her confinement, and was admitted to the Kensington Hospital for Women. Examination showed a large inflammatory mass in the pelvis, absolutely anchored to the left pelvic wall. She was under observation for two weeks, with the temperature fluctuating between 99° and 102°F., with the general evidences of mild septic absorption, such as anorexia, sweats, chilly sensations, and increased pulse-rate.

* Reported in Annals of Gynæcology and Pædiatry, January, 1893.

Believing that pus was present in the pelvis, either in the form of a true pelvic abscess or a pyosalpinx, an abdominal section was made on June 26, 1893. The following conditions were found: The uterus was fairly well involuted and was displaced upward and backward by a mass in the left broad ligament. The right broad ligament and the right Fallopian tube and ovary were entirely normal, as was demonstrated not only by touch but by delivering the ovary and tube through the abdominal incision. The omentum was adherent to the anterior face and upper border of the left broad ligament in front of the Fallopian tube. This adhesion was separated. The left ovary and tube were found to be entirely normal; the meso-salpinx being normal, soft, and movable. This was demonstrated not only by touch, but by vision, the woman being in the Trendelenburg posture, so that the entire left side of the pelvis was in plain view. The left broad ligament was very much infiltrated with inflammatory material and firmly anchored to the anterior and left bony wall of the pelvis. Fluctuation was not apparent. It was determined to close the abdomen, and if septic symptoms persisted to open the broad ligament from below. That portion of the omentum which was adherent to the broad ligament was ligated and cut off. A small gauze drain was placed against the broad ligament where the omentum had been separated, so that should pus make its appearance at this point it would find its way out through the abdominal incision.

The patient's convalescence was uninterrupted; the temperature rapidly dropped to the normal, and her general condition steadily improved. The gauze drain was removed, good union of the abdominal incision was obtained, and the patient was discharged from the hospital at the end of four weeks. In the meantime, not only had her general condition very much improved, but the pelvic mass had almost disappeared.

This patient consulted me January 9, 1894, to ascertain the cause of a suppression of menstruation of three months. I found her to be between three and four months pregnant. A careful examination of the left broad ligament failed to discover any evidence of the former cellulitis, the left broad ligament feeling exactly like the right one.

The evidence of the existence of acute puerperal cellulitis as a primary condition in this case is absolute. There was not even a complicating pelvic peritonitis in the ordinary sense of that term, merely a point of adhesion between the omentum and the broad ligament, which was, of course, due to a small circumscribed area of peritonitis. I was able to demonstrate these conditions to a number of physicians who were present, including among others, Dr. Fullerton, of the Woman's Hospital.

What I wish especially to insist upon is that in this case neither Fallopian tube was involved in the inflammatory process, that both were entirely normal. The left Fallopian tube and its mesentery were scarcely even congested. The circumscribed area of peritonitis where the omentum was adherent to the broad ligament was plainly due to the fact that the inflammation had extended directly through the broad ligament to the peritoneum, leading to the adhesion of the omentum. That this is possible has been denied by those who maintain that all pelvic inflammation is due to infection which has spread through the Fallopian tubes. In this case the conditions present were unmistakable.

We thus have seven cases in all of which, except the third and fifth, an abdominal section was made, so that we have the evidence not only of the usual physical examination, but also that obtained from an intra-peritoneal examination. In Cases I., II. IV., and VII., the abdomen was opened and the uterine appendages were examined, and it was demonstrated that they were either free from disease, or at the most, lightly attached by recent adhesions. In these four cases there is not a shadow of a doubt that the disease was in the broad ligament, and that it spread to the ligament directly from the uterus or vagina by way of the lymphatics.

Case VI. was undoubtedly not a case of pyosalpinx, and I have no question myself that the pus was located in the broad ligament. A carping critic might affirm, that even although it was not a pus tube, that the pus was intra and not extra-peritoneal, and that it was due to suppurative peritonitis. My opinion that the pus was in the broad ligament is based upon the fact that the pelvic exudate was anchored to the anterior and right pelvic walls, and that when I cut down upon the

mass I recognized the uterus and tore through the broad ligament with my finger in front of the Fallopian tube.

The evidence in Cases III. and V. is not so absolute as in the others, and they are included in this list not for the sake of *demonstrating* the occurrence of puerperal cellulitis, as is done by the other cases, but because of their relative bearing upon the subject.

The foregoing cases demonstrate several interesting facts with reference to obstetrics and gynæcology:

1. That in the puerperal state, pelvic cellulitis and true pelvic abscess occur as the result of septic inflammation.
2. That inflammation may spread from the vagina or uterus along the pelvic lymphatics to the broad ligaments without involving the Fallopian tubes.
3. That peritonitis can be set up by the spread of inflammation from the broad ligaments to the peritoneum without involvement of the Fallopian tubes.
4. That very extensive pelvic exudate and intra-peritoneal adhesions can be absorbed.

It hardly seems worth while to bring evidence to bear in support of our first proposition, and it would not be called for were it not that a few men of wide experience maintain the contrary. Being able to present absolute evidence in the shape of carefully and thoroughly observed cases occurring in my own practice, I shall not take the time or trouble to make reference to the literature.

What I have said concerning proposition one is equally true of proposition two, which is distinctly proven by certain of the foregoing cases. Case VII. is a beautiful illustration of the fact that a very extensive puerperal cellulitis can be present and yet the Fallopian tubes be entirely healthy. In this case they were scarcely, if at all, congested, and the meso-salpinx was entirely free from infiltration.

The third proposition is likewise proven, especially by Cases IV. and VII. In both of these cases the omentum was adherent to the broad ligament, although the tubes were free from disease. I have no doubt that pelvic peritonitis is usually due to the spread of inflammation from the endometrium through the Fallopian tubes to the peritoneum, but these cases show that this rule is not without exceptions. Numerous other exceptions have come under my observation. For instance, a short time ago I did a hysterectomy for a fibroid tumor, in which the tumor, being impacted in the pelvis, was adherent to the rectum and posterior pelvic wall, over an area of at least nine square inches, and yet in that case the Fallopian tubes were entirely normal. In several cases of appendicitis I have found the peritonitis to extend to the pelvis, the Fallopian tubes having nothing to do with its occurrence. Moreover, it is a well-known fact, that when small tumors, especially dermoids, become wedged in the pelvis, or become twisted upon their pedicles, that peritonitis ensues. Likewise, that in cases of malignant disease of the abdominal or pelvic organs, adhesions are almost always present. Therefore, it must be admitted that pelvic peritonitis can occur independent of salpingitis.

Case VI. demonstrates our fourth proposition. In that case the entire right lower quarter of the abdomen was fused together by recent peritoneal exudate, and light adhesions had formed in the left half of the pelvis, yet eighteen months later, when the abdomen was reopened, the entire mass of adhesions had been absorbed, with the exception of a small point between the omentum and right broad ligament, and another small point between the omentum and the hernial sac. Owing to the very extensive character of the adhesions in this case, it is a striking example of the fact that recent adhesions can be entirely absorbed.

Two women of the seven whose cases have been detailed in this report have been delivered of living children since their recovery from the attack of acute puerperal pelvic cellulitis.* The subsequent history of four of the other five women is unknown to me. The fact that two of these women have borne children is of interest because of its bearing upon the question of the relation of pelvic exudates to sterility. As this paper has dealt only with demonstrated facts, I shall merely suggest that the occurrence of pregnancy after the existence of extensive exudates, forming during the puerperal state, is best explained in many cases by the fact that the condition present is a puerperal cellulitis rather than a diseased tube. It is a severe tax upon my credulity to accept the state-

* Since writing this article I have learned that Dr. Himmelwright's patient (Case III.) has been delivered of a living child, after a normal labor.

ment that extensively diseased tubes, more especially pus tubes, can so far recover as to permit the occurrence of pregnancy; and I believe that the true explanation in not a few cases of pregnancy following the recovery from puerperal pelvic inflammation is, that the disease was originally in the broad ligament and not in the Fallopian tube.

In conclusion, I wish to say a few words concerning the relative frequency of acute puerperal cellulitis and inflammation of the Fallopian tubes. I believe as firmly as any one, that pelvic cellulitis and true pelvic abscess are comparatively rare conditions, and that the usual variety of pelvic inflammation is a salpingo-peritonitis. I have not met with pelvic cellulitis except in the puerperal state, and have no reason to believe that it occurs in the non-puerperal state, except as a result of infected wounds of the vagina and perineum. As such conditionsare very infrequent, a pelvic cellulitis in the non-puerperal state would be a surgical curiosity.

I have added these remarks lest it might be inferred by the unthinking that I am desirious of supporting the old and abandoned theory of Nonat and Emmet concerning pelvic inflammation. At the same time I am glad to be able to present incontestable proofs of the occasional occurrence of acute puerperal pelvic cellulitis and true pelvic abscess.

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### CHLOROSIS WITH MENORRHAGIA.

Dr. Ch. Liegeois (*La Semaine Médicale*, No. 22, 1894) prescribes in chlorosis with associated menorrhagia, the following pill, with advantage:

| | | |
|---|---|---|
| ℞ | Protochloride, or Sulphate Iron..2 | 50 (grs. xxxviij). |
| | Extract Hyoscyamus.....1 | 0 (grs. xv). |
| | Alcohol. resinous Ex. Hydrastis..5 | 00 (ʒj ¼). |
| | Licorice Powder.....5 | 0 (ʒj ¼). |

Sufficient for one hundred pills—gelatine coated. Two pills at each meal during the menses and the intervals as well.

### TREATMENT OF SYPHILIS.

Prof. Lang (*Gazzetta Degli Ospitali*, No. 26, 1894) though an advocate of the internal treatment of syphilis, recognizes the disadvantages of this method: the difficulty of exact dosage and the dangers of mercurial poisoning. To remedy these inconveniences he employs the following formulæ:

| | | |
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| ℞ | Protoiodide Mercury.....1 | 50 (grs. xxij). |
| | Extr. Opium..... | 50 (grs. vijss). |
| | Lanoline.....1 | 50 (grs. xxij). |
| | Sugar Milk..... .4 | 50 (ʒj ½). |

Sufficient for fifty pills. One to two per diem.

| | | |
|---|---|---|
| ℞ | Calomel.....2 | 50 (grs. xxxvij). |
| | Extr. Opium..... .... | 25 (grs. iv). |
| | Lanoline .....1 | 50 (grs. xxij). |
| | Sugar Milk.....3 | 75 (grs. lv) |

Sufficient for fifty pills. One to two a day.

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|---|---|---|
| ℞ | Corrosive Sublimate..... | 25 (grs. iijss). |
| | Extr. Opium..... ..... | 50 (grs. vijss). |
| | Lanoline.....1 | 50 (grs. xxij). |
| | Sugar Milk .....3 | 75 (grs. lv). |

Sufficient for fifty pills. One to two per diem.

If necessary, he also associates the use of arsenic or the iodide of potash, with these formulæ; also in pill-form, according to the following formulæ:

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|---|---|---|
| ℞ | Iodide Potash.....10 | 0 (ʒijss). |
| | Sugar Milk..... 5 | 0 (ʒj¼). |
| | Lanoline..... 3 | 0 (grs. xlv). |

Sufficient for fifty pills. Three, ten, or fifteen a day.

| | | |
|---|---|---|
| ℞ | Arsenious Acid..... | 50 (grs vijss). |
| | Sugar Milk. .....6 | 50 (ʒj ¼). |
| | Lanoline.....3 | 00 (grs. xlv). |

Sufficient for one hundred pills.

The addition of lanoline, which melts at the temperature of the interior of the body, and the sugar of milk which easily dissolves in the gastro-intestinal juices, provide that no particles of these drugs pass through the digestive tract unaltered, so that one may be certain that the quantity of the drug ingested will be absorbed. Thus exactness of dosage and prevention of poisoning are assured. If one will employ a hypodermatic preparation he warmly recommends, from a long experience, the following:

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|---|---|---|
| ℞ | Mercury..... | |
| | Lanoline, ana.....4 | 0 (ʒj). |
| | Olive Oil.....6 | 0 (ʒjss). |

Inject five ccms. under the skin of the back every three to four days at the beginning, every five to eight days when the symptoms retrogress progressively, and every eight to fourteen days—not more than twice—when they have completely disappeared. He avoids injections into

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

the nates for fear of wounding veins, producing pulmonary embolism, suppuration, etc. The injection into the skin of the back is made four centimetres to the left of the spinal column where they may be continued in the same vertical line four cms. from each other; thus on one side one may inject from five to six times. The other injections may be given on the opposite side. A radical treatment requires from eight to twelve such injections; recurring forms from four to eight. If more than twelve are necessary then make them in a vertical line, eight cms. from the median line.

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TREATMENT OF RENAL LITHIASIS.

In *L'Union Médicale*, No. 37, 1894, the following treatment of renal lithiasis is recommended:

Quiet the pain with one or two injections of morphine. Put the patient into a warm bath for an hour or an hour and a half; repeat this during the day if necessary. In children over five years, the same treatment as adults; if less than five years, warm baths, very hot poultices to the abdomen, or if not relieved a chloroform stupe. If the pain is intolerable, ether or chloroform inhaled to slight anæsthesia. If the stomach is tolerant, a little morphine and belladonna. Cold rectal injections.

SUBACUTE CRISES.—A rigid diet, the benzoate of lithine. At each meal gms. .50 (grs. vijss) of salol. Milk is an excellent article of diet, white meats, spinach, lettuce, much fruit. Eat but little and masticate well. On arising drink a glass of pure water. The patient should drink enough, either during meals or in the intervals, to be able to pass a quart and a half of urine in a day. Avoid constipation. If bowels are irregular, take from a teaspoonful to a tablespoonful of the tartrate of potash and soda in a glass of the liquor from macerated licorice roots. Evacuate the bladder frequently. Exercise which is most agreeable to the patient. When once sweating, have him change his linen and rub himself dry. Avoid taking cold above all things. Alkaline baths once or twice a week.

DRUGS.—Two principal indications: alkaline medication and diuretics.

*Alkalies.*—The benzoate of lithia, one to two grams (grs. xv-xxx) a day, in two doses, an hour before dinner and supper. Continue these for ten days of each month, and the remaining twenty days the diuretic treatment. The bicarbonate of soda is much used:

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|---|---|---|
| Bicarbonate Soda | 2 | o (grs. xxx). |
| Powdered Tartaric Acid | 1 | o (grs. xv). |
| Calcined Magnesia | | 75 (grs. xij). |

Sufficient for one powder. One an hour before each dinner and supper. A glass of milk after the powder.

*Oxalic Deposits.*—Avoid foods rich in oxalic acid: gooseberries, tomatoes, pieplant, milk, waters surcharged with gases, and cheese. Order meats, fish; the phosphate of soda, one gram (grs. xv) after each meal and on going to bed. Diuretics. It may be observed that in children which eat too much of soups and boiled dishes to replace them by eggs and milk.

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TREATMENT OF PSORIASIS.

Dr. Coffin (*Le Sperimentale*, No. 6, 1894) states that treatment will vary according to the form of the disease.

In cases of moderate severity he removes the scales with alkaline baths, soaps, etc. Then he employs the following:

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| Glycerolate of Starch | | |
| Oil Juniper, ana | 100 | o (℥iijss). |
| Green Soap | 5 | o (℥j ¼). |
| Salicylic Acid | 3 | o (grs. xlv). |

Every three or four days the affected spots are washed with warm water and tar soap. Pyrogallic acid or chrysarobin may be used instead.

In diffuse forms with pronounced inflammatory symptoms he employs, with advantage, prolonged baths—for five to six hours—and applications of mild salves.

In cases with limited eruptions he employs Vigo's plaster.

In obstinate cases he removes the scales and applies the following salve:

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|---|---|---|
| Ichthyol | | |
| Salicylic Acid | | |
| Pyrogallic Acid | ää.. 2 | o (grs. xxx). |
| Vaseline | | |
| Lard | | |
| Lanoline | ää..30 | o (℥j). |

The patient should be well nourished and avoid coffee, alcohol, tea, etc. Arsenic is only indicated when the disease has ceased to progress.

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A woman can walk and a woman can talk,
And fritter away a whole day;
But with all of her folly she can't jump a trolley,
Because she ain't built that way.

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SATURDAY, MAY 26, 1894.

## EDITORIAL.

### A CORDIAL INVITATION.

Two years ago the American Medical Association met in Detroit, last year the meeting place was Milwaukee, and this year the Association will enjoy the hospitalities of the profession of the Pacific coast, during its session in San Francisco. Since for three consecutive years the meetings have been held in Western cities, it would seem to be in the natural order of things for the meeting of 1895 to be held in some Eastern locality.

In anticipation of this probability the REPORTER has called the attention of the citizens of Asbury Park, N. J., to the desirability of securing the meeting of the American Medical Association for 1895, for that city. A year ago, at the suggestion of the REPORTER, Asbury Park extended a similar invitation to the Association, but for sufficient reason an invitation from San Francisco was accepted. The invitation to become the guests of Asbury Park will again be extended to the Association, and there are many reasons why it should receive the most favorable consideration.

Very briefly stated, we may say that Asbury Park is located on the northern coast of New Jersey, about midway between New York and Philadelphia, and within easy communication of these two cities, the greatest medical centres of of America. It is essentially a health and pleasure resort. It is the greatest, cleanest, healthiest; the most attractive, most desirable and most popular of all the health and pleasure resorts on the Atlantic coast. Its facilities for the entertainment of large numbers of visitors are superior; its numerous hotels being fully equipped with all modern conveniences, enable it to handle with ease the influx of three score thousand or more visitors, who from year to year make it their summer home.

The desirability of the place for the meeting of large bodies of men is sufficiently indicated by the fact that during the coming summer there will be held at Asbury Park, the annual meeting of the National Editorial Association, and, in the height of the season, the many thousands attendant upon the meetings of the National Educational Association will be the guests of the city. Other conventions

also will be assembled there during the coming summer.

Among the conveniences of Asbury Park may be mentioned its electric street railways, its water supply from artesian wells, its lighting by electricity and gas, a system of sewerage which is conceded by sanitary experts a model system, and a Board of Health, whose conception of duty is to actively search out "nuisances" of any character and promptly eliminate the same, instead of carefully concealing them.

Of the physical attractions of the place it is not necessary to speak here, save to mention its famous plaza, the greatest and most popular promenade in the new world.

Another point deserving full consideration is the fact that the invitation to the American Medical Association is extended directly by the city authorities, whose assurances are not problematical, and who assume all responsibility for carrying out the details as outlined in the invitation. As a result, this will relieve the local profession of many perplexing conditions, secure concessions which it would be impossible for any body of medical men to obtain from authorities who were but slightly interested, if not utterly indifferent to the possible benefits of such a meeting within their territories.

In the one item of transportation the concessions given at the instance of the municipal authorities may prove a greater saving to the Association than the sum of all concessions otherwise made to its own officials. And where, as in the case of Asbury Park, all business interests combine in extending the invitation, the aggregate of the concessions made will be of great economic value to the Association.

When the REPORTER offered the suggestion, it claimed no authority in the premises and held out no inducements. The citizens of Asbury Park accepted the suggestion and acted upon their own responsibility.

They already have the greatest summer resort for health and pleasure on the Atlantic coast. They are determined to make it the greatest all-year-round resort in America. To this end they invite the the closest personal scrutiny of their conditions, natural and acquired.

Neglecting no other means of informing the public, they seek to substantiate their claims by affording to all opportunity of proving them by individual experience and observation. Hence they offer the most generous hospitality and entertainment of representative bodies of all kinds, —a policy the wisdom of which has been fully demonstrated in the past.

## About Mushrooms.

"*A Guide to the Study of Esculent and Poisonous Fungi*," *by Julius A. Palmer, Jr. Lee & Shepard, Publishers, Boston, Mass. $2.00.*

The work is a painstaking effort to point out accurately the difference between esculent and poisonous fungi, and to a great degree must be considered by the medical profession as a valuable text-book. The author upsets the popular theory, among laymen at least, that the changing in color of some fungi indicates their poisonous nature.

"Nothing could be more false. There is one, *Boletus cyanesceus*, which turns throughout the most beautiful blue, many that assume this color in lighter shades, and one that turns blood red: this change showing itself wherever the substance is bruised or cut. These are all esculent, while the dangerous Amanita remains the purest white under all conditions; that eatable mushroom, the nearest resembling the Amanita, may be distinguished by the fact that its gills turn pink or reddish the moment it feels the fire."

Copious extracts from previously published articles are given with the author's comments thereon.

As long as our people persist in the habit of gathering mushrooms(?) basing their ability to distinguish the difference between eatable and poisonous varieties on their knowledge of the characteristic of two or three sorts, just so long will we be in need of authoritative text-books (of which we now have too few) on the effects of each poisonous variety and the proper treatment of the patient.

# ABSTRACTS.

## NATURE OF PERITONITIS.

At a meeting of the Medical Society of London, the author, Mr. Treves, (*Lancet*, 1894) delivered the first Lettsomian Lecture on the Nature of Peritonitis, which is as follows:

I have ventured to select peritonitis as the subject of these lectures, not only on account of the fact that the diseased conditions known by that name still occupy a terrible prominence among the causes of death, but because the present time appears to be peculiarly convenient for reviewing the clinical and pathological aspects of this fatal trouble, and for criticising opinions which the custom of years has endued with a spurious appearance of accuracy. By peritonitis is understood an inflammation of the peritoneum. From the limited standpoint of morbid anatomy no exception can be taken to this definition; but when it is assumed that the various clinical phenomena which are classed together under the title of peritonitis are due either solely or in the main to an inflammation of the great serous membrane, then the definition becomes to some extent misleading, for peritonitis, clinically as well as pathologically, has comparatively little to do with inflammation of the peritoneum, and it would be erroneous to state that the majority of those who die of what is called peritonitis die of a peritoneal inflammation. Inflammation is by many still referred to as a calamity, as a thing that is violent, as an utter evil, and as an ill wind that can blow no other than ill, and the measures to be directed against it are commonly considered to be as drastic as those necessary to arrest the progress of fire and pestilence. This view of the inflammatory process needs to be amended, for it is by this process alone that the poison in an inoculated wound is destroyed and the growth of a parasite is arrested. But for inflammation, a man who is accidentally inoculated with a septic micro-organism becomes at once little more than a test-tube prepared for the favorable development and culture of the particular coccus or bacterium; he may be regarded as an organism not far raised above the level of a peculiarly-shaped mass of agar-agar. In a case of tuberculous phthisis it is not the inflammation which is to blame as the cause of death, but the bacillus which has produced it; the inflammation of the lung prolongs the infected man's life, and his prospects of improvement and recovery depend almost wholly upon it. The "white swelling" of a tuberculous arthritis illustrates the often successful attempt of the organism to rid itself of the tubercle bacillus by means of the inflammatory process, the latter being not a malignant energy working for evil, but a process the object of which is protective, and its end is shown by the freeing of the body from noxious organisms which lead to death. Yet the process may be excessive in individual cases, may be attended by certain disasters, and may fail to some degree in its purpose. It may be assisted and modified by treatment where the latter is directed towards removing the irritants from the tissues. And what has been said of inflammation in general applies equally to inflammation within the great serous cavity of the abdomen; it is an attempt on the part of the organism to avert a too potent cause of death.

The relation of what is clinically known as peritonitis to the inflammatory process requires careful consideration. In the larger number of fatal cases the leading symptoms are those of toxæmia. So far as the clinical aspect of a patient dying from peritonitis goes, he might be dying from snake-bite or from cholera poison, and after death the amount of inflammation discovered is out of all proportion to the phenomena which preceded death. A little injection of the peritoneum, with loss of its polished surface, a little general stickiness with a few frail adhesions, and a scanty mixture of pus and turbid fluid, are often all that is found. This is not the formidable kind of effusion which would be expected in a case of death from inflammation. The larger the dose of poison the quicker is the fatal result and the fewer are the manifestations of peritonitis; this is true both of human beings and animals. Death in the acute cases is said to have resulted from shock caused, in the majority, by profound nerve irritation from the sudden spreading of noxious micro-organisms or their products, over a

wide and sensitive surface. After a smaller dose life lasts for three or four days with symptoms of acute peritonitis, and yet after death the serous membrane shows but the early manifestations of inflammation. In other instances recovery follows after a more or less desperate illness, and this may be effected with or without the development of encysted suppuration. Of course the power of resistance of the individual must be considered as well as the dose of the poison. The favorable cases of peritonitis are usually those in which suppuration is most pronounced, whilst the most acute and unfavorable cases show the least inflammatory changes.

The surgical treatment of acute diffused peritonitis as a purely inflammatory affection by incision and evacuation of the effusion has been comparatively unsuccessful. The mortality attending the operation for strangulated hernia has not greatly improved since the introduction of aseptic measures in surgery, and in cases in which neither gangrene nor perforation of gut occurs, there is something besides mere inflammation which leads to death.

All this is evidence that in the larger proportion of examples of fatal peritonitis the leading symptoms are those of poisoning and not of inflammation; but it must not, on the contrary, be assumed that inflammatory phenomena are wholly subordinate in peritonitis, for in pelvic troubles and in appendix cases the signs of inflammation are paramount. It is obvious that the peritoneum has peculiarities and that there are phenomena attending its lesions which a reference to like disturbances in other serous membranes cannot explain. Suppurations of the pleura have not the same gravity, and this is not explained by the different extent of surface in the two cavities or by a resulting disturbance of function in the viscera covered by the respective membranes. So far as the function of viscera is concerned the visceral disorders in many cases of severe lead poisoning which end in recovery, are more considerable than they are in some examples of peritonitis which end fatally in a few days.

The following points may be noted with regard to the peritoneum:

1. Its surface is probably as great as that represented by the whole integument of the body.

2. It can absorb an amount equal to from three to eight per cent. of the body weight.

3. It offers a limited resistance to septic organisms and their products, the resistance varying within wide limits and being affected by age and disease.

4. No tissue in the body provides more favorable conditions for healing.

5. It does not show the same degree of vulnerability in all parts, nor are all portions of it alike in the manner in which certain lesions are responded to. The part covering the small intestine is most susceptible; the parietal layer is least so. Localized forms of peritonitis and encysted exudations are comparatively uncommon in the large area occupied by the small intestine and are commoner in the subphrenic region, between the dome of the diaphragm above and the transverse colon below, to the outer side of the cæcum and in the pelvis. Extensive inflammation may occur in the hepatic and pelvic regions without inducing very alarming symptoms. Injuries of the intestine are usually fatal, while lesions of the liver and bile passages are commonly slow and moderate.

6. The peritoneum appears to be possessed of great sensitiveness, peculiar and not quite comparable to that possessed by the skin; this is a matter of moment in the production of shock. The sensibility is dulled or lost when the surface is inflamed or covered with lymph.

7. A matter of great interest, though of some obscurity, concerns the condition of pressure within the abdominal area, and the effects which follow the disturbance of it. The cavity of the peritoneum is, of course, a potential space, and the creation of an actual cavity after incision will produce a disturbance of pressure relations which cannot be without effect on the sensitive tissues, and thin-walled blood vessels within the abdominal parietes.

The effect of a mere incision into the abdomen is often very remarkable. To the surprise of the operator, a simple incision into the abdomen in a case of tuberculous peritonitis, followed by evacuation of the fluid, has been succeeded by complete cure, and numerous instances are on record in which simple incision has entirely relieved abdominal trouble; in many of these neurosis as a causative factor of the trouble seems to be out of the question. There are certain other points in connec-

tion with intra-peritoneal pressure which remain to be mentioned. In the first place gravity does not appear to follow the usual lines within the abdomen. In the second place the frequency with which the escapes of fæces fails to take place in spontaneous perforation of the intestines, and in punctured wounds of that viscus is somewhat remarkable. Both Travers and Ziegler account for this by the state of intra-abdominal pressure, and Klemm asserts that the idea of the wound in the bowel being blocked up by prolapsed mucous membrane is fallacious.

8. The last point concerns the possibility of the peritoneum acquiring some degree of immunity from septic infection. This condition of immunity can be produced artificially in animals and appears to be possible in the human subject. Other things being equal, an operation carried out within the abdomen of a person who has had chronic peritonitis or who has exhibited repeated sub-acute attacks, and whose peritoneum presents substantial adhesions, is likely to be attended with better results than when the peritoneum is found to be wholly undisturbed.

In advanced cases of appendix trouble the disproportion which is often noted between the constitutional disturbance and the local condition discovered at the operation, appears to be capable only of the same explanation. In looking over the records of laparotomy performed for perforations in the stomach or bowel, it is impossible not to be struck with the fact that in many of the successful cases, there had been long antecedent visceral or peritoneal trouble.

## TREATMENT OF EPILEPSY.

Prof. Lemoine (*Revue Generale de Clin. et Therap.*; Cincinnati *Lancet Clinic*) recommends, in the management of epilepsy, an extensive surveillance, of which the most important points are as follows: The mental diet of the patient should be carefully watched, that he be kept free from all physical and mental exhaustion, psychic excitement, sudden alterations of the temperature, and disturbances of digestion. Alcoholic drinks and coffee are to be forbidden, and constipation to be treated. In the treatment of the attack itself, he recommends a rectal injection containing two grammes (30 grains) of the bromide of potash and chloral, to be administered in the intervals between attacks. If it fail to act after four hours, then give a second one, and even a third, after eight hours. During the attack the patient should be laid either on the floor or a bed and the garments loosened around his throat. In case the seizures rapidly re-occur (he has seen 220 within twenty-four hours), the patient should be placed in a dimly-lit room, and, after cessation of the attacks, it is best to have the patient rest in bed for one day, with substantial but not bulky diet. In traumatic epilepsy he recommends operative interference, while, if it depend upon syphilis, the iodide of potash and mercury are the best means of treatment. For three weeks inunctions of six grammes (1½ drachms) of mercurial ointment are rubbed in daily, and then the iodide in rapidly increasing doses, from two to eight or ten grammes per diem. After cessation of the attacks the inunctions and the potash salt are continued from one to three months longer and the latter for a year, after each meal. By the use of a great deal of milk the tolerance for these remedies is increased. In menstrual epilepsy he administers every three days ten grains of antipyrine and four grains of the bicarbonate of soda, and as soon as the arterial tension is affected he adds a grain of the powdered leaves of digitalis. If there are, simultaneously, pains in the hypogastric region, he has an enema containing ten drops of the tincture of opium given. In the employment of the bromides the addition of hyoscyamine is of great service. He advises the following combination:

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|---|---|
| Bromide of potash | gms. 30 |
| Bromide of sodium | |
| Bromide of ammonium | āā gms. 15. |
| Hyoscyamine | mgms. 15 |
| Water | qt 1 |

If signs of bromism appear he substitutes the bromide of gold for the other bromides, dissolving three grains in sixteen ounces of water. Of this mixture one or two teaspoonfuls per diem may be given. The bromides he always prescribes in watery solutions, and never in syrup. The doses should be large. Borax may be given with advantage in a daily dose of two or three grammes (30 to 45 grains).

## THE AMERICAN MEDICAL ASSOCIATION MEETING.

The American Medical Association will meet in San Francisco, June 5th to 8th, inclusive.

The entire work of the Association will be done in Odd Fellows' Building, cor. Market and Seventh streets.

Exhibition room for instruments, pharmaceutical preparations, etc., is also in this building.

Registration will begin in Marble Hall, Palace Hotel, on Monday, June 4th, when all who arrive early enough should register to avoid the rush on Tuesday. Working hours of the Sections will be 9 to 12 and 2 to 5—except forenoon of the first day.

The general assembly will convene at 10 o'clock on Tuesday.

The following hotels have quoted special rates for members and their families: Palace, Grand, Lick, Russ, Occidental, California, Baldwin and Pleasanton.

There will be room for all. Visitors desiring to engage rooms in advance can do so by communicating directly with the hotels, or with R. A. McLean, No. 305 Kearny street, Chairman Committee on Hotels.

Headquarters at Palace Hotel, where there will be a concert in the Grand Court, Monday evening, June 4th.

Tuesday evening a reception will be held at Pioneer Hall, Wednesday evening at Cooper Medical College, Thursday evening at the Midwinter Fair, and Friday evening at the Hopkins Art Institute. The Ladies' Committee on Reception—Headquarters Palace Hotel—will provide entertainment for visiting ladies during the day.

Saturday will be devoted to an excursion around the Bay, starting at 9 o'clock and returning at 5, passing in view of the Irving Scott Ship-building Yards, Spreckles' Sugar Refinery, U. S. Military Posts-Alcatray, Fort Mason, Presidio, Fort Winfield Scott, and out to the "*heads*" for a touch of old ocean; returning, pass U. S. Quarantine Station and land at Mare Island, where an hour will be spent inspecting the Goverment Hospital and reconstruction works.

Railroad tickets will be good for return till July 15th, members will therefore have time to make numerous side excursions in the State, after the meeting. On the S. F. & N. P. Railway, the rate for such excursions will be a single fare for a round trip.

The S. P. Co.'s rate will be one and a fifth to one and a third fares for a round trip. Some of our seaside and mountain resorts, Mineral Springs and Sanitariums will well repay for time spent on a visit. Among them are Santa Cruz, Del Monte, Santa Barbara, Santa Monica and Coronado; peerless Yosemite and her giant Sequora forests, Lake Tahoe and Mount Shasta; Paso Robles, Arrowhead, Gilroy Mt., Byron, Soda, Vichy, Geysers, Harbin, Bartlett, and Highland Springs, all possessing medicinal virtues, and justly popular with our own people.

Special inducements are offered at all these places; Paso Robles Hotel offers the best entertainment for members at half regular rates, and Highland Springs, in the "Switzerland of America," with its latch string on the outside, invites members to come and partake of its hospitality, free as the bubbling waters of its springs.

June will be the height of the season for the Alaska excursion, unequaled by any other trip in the world save that to North Cape.

Members who desire to secure accommodations in advance for this trip can do so by applying to the Committee of Arrangements.

Any one desiring to secure space in Exhibition Hall should apply to R. L. Ridgon, Nucleus Building, Chairman Committee on Exhibits.

If members who are getting up excursions will immediately send us approximately the number we may expect from their respective localities, it will simplify our work of preparation for reception and entertainment.

We request also that they will wire us the exact number on departure of their trains.

R. H. PLUMMER,
Chairman.

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THE teacher was trying to teach Jones the alphabet. She pointed to the letter X.

"What's that letter?"

Jones (bashfully)—"Guess don't know, marm."

Teacher—"O, yes. Think a minute."

Jones (brightening) —"Yes, marm. Dat's daddy's name.—*Boston Globe.*

# SOCIETY REPORTS.

## THE SURGICAL SECTION OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

*Meeting of April 13, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

### RADICAL OPERATION FOR CONGENITAL HYDROCELE IN AN ADULT.

Dr. Thomas S. K. Morton presented a man, aged twenty years, upon whom he had operated six weeks previously for congenital hydrocele of the tunica vaginalis testis. Incision and ligature of the neck of the sac, with subsequent packing with iodoform gauze, was the method of treatment adopted.

The symptoms were: large fluid distention of the right tunica vaginalis; pain and sense of weight; disappearance of the fluid over night and upon prolonged pressure of the scrotum, together with profound melancholy incident to the patient considering himself subject to serious disease of the sexual apparatus.

He was etherized and a four-inch incision made in the scrotum and sac. A probe could then be passed upward through the patulous but very small calibred unobliterated funicular process into the abdominal cavity. A curved needle armed with strong chromicized catgut was passed through the tissues surrounding this sinus beneath the tunic, avoiding the vas deferens and spermatic vessels, and brought out at the point of entrance. When the ligature was tied down tight an effectual approximation of the neck of the sac at the external ring was secured, and all communication with the peritoneal cavity cut off. The sac was then carefully searched for fibrous or other bodies; none being found, the cavity of the tunic was lightly stuffed with iodoform gauze after its edges had been sewn to the skin margins of the wound by a continuous suture.

The packing was renewed every two days. He arose in five days and returned to work, wearing simply a pad of bichloride cotton held in place by a suspensory bandage, in ten days. The wound finally closed, under stimulation by twenty grains nitrate of silver solution, within three weeks. The result, as demonstrated by the patient to the Section, was perfect, and the man had returned also to a normal mental condition.

### PICKAXE WOUND OF BRAIN.

Dr. John B. Roberts presented a patient who had recovered from a pickaxe wound of the brain, and said:

"The man was brought to me at the Polyclinic Hospital with a small wound of the skull through which brain substance oozed. He had been struck with a pickaxe shortly before admission to the hospital. Within an hour and a half of the injury I laid open the skull, and found pieces of bones driven into the brain. I used the mallet and chisel to cut away the edge of the fracture, and with forceps removed the fragments of bone from the brain tissue. My finger passed nearly an inch down into the brain structure, which was soft. I then washed away, with a stream of bichloride solution, the soft brain tissue. As there was a good deal of oozing from the pia I stuffed a small piece of gauze into the wound to make a little pressure, sewed up the scalp wound at the ends, but allowed the gauze to stick out at the centre. The patient had union by first intention where the edges were sewn together; and second intention where the wound had been kept open by the gauze, which was removed at the end of twenty-four hours. At the present time the wound is healed and the man well. The pulsation of the brain can be seen where the bony wall is absent. It is four weeks since the accident. If trephining had not been done I believe the man would have died of cerebral abscess."

### MISPLACED TESTICLE RESTORED TO ITS PROPER POSITION.

Dr. Edward Martin presented a case of "Misplaced Testicle," the patient being a boy aged nine years. He had the testicle normally descended on the left side, but on the right side it had gone into the perineum, lying an inch in front of the anus. It was freely movable and normal in size. The difficulty, of course, was, that from its false position the gland was exposed to traumatism. The boy had already suffered from one attack of acute orchitis. The history of these cases of misplaced testicle shows that the gland is at first entirely normal in structure and development; but that it finally, simply from chronic inflammation incident to repeated slight injuries, atrophies and becomes useless; hence the great importance of shifting the still normal testicle to its proper protected position.

The only method to be considered in this case was a free incision, division of adhesion, and replacement. The testicle was cut down upon. The cord was dissected free, some dense fibrous bands passing backward toward the anus and being adherent to the epididymis were cut, an opening was made in the tissue of the scrotum, and the testicle was secured in its proper position by two stitches passing through the lower part of the vaginal tunic and the inner skin surface of the base of the scrotum. The long wound was united in a cross direction, thus deepening the scrotal sac. The wound healed without suppuration, and the testicle lies in a perfectly normal position.

The boy now perfectly well and able to ride a bicycle without discomfort.

### PARALYSIS OF LONG RESPIRATORY NERVE OF BELL.

Dr. Martin also reported a case of paralysis of the long respiratory nerve following typhoid fever. During the fourth week of convalescence from typhoid fever it was noticed that the angle of the right scapula became very prominent. This was diagnosed as a dislocation of the scapula—that is, a slipping of the lower angle of the scapula over the fibres of the latissimus dorsi muscle.

On examination it was at once apparent that the serratus magnus was palsied. In addition to its respiratory function the serratus magnus is directly concerned in the movements of the shoulder. By its tonic contraction it holds the scapula, especially its lower angle, closely applied to the chest, and when thrown into full action rocks this bone outward, thus enabling the arm to be carried upward. The deltoid can lift the arm out and up until it is held at right angles to the long axis of the body; the rocking of the scapula by the serratus carries the arm up. Inability to raise the arm higher than the shoulder was well-marked in the case. Under treatment by massage and electricity the patient has recovered in a great measure. He is not absolutely cured, but the outlook is good, as I believe it is in the majority of these cases of neuritis after typoid fever. The photographs show very perfectly both the disability and the wing-like projection of the shoulder-blade.

### CURED FRACTURE INVOLVING THE ATLAS AND AXIS.

DR. M. H. CRYER: This is a specimen of which I do no know the history, except that it was found in a lot of bones when the Philadelphia Dental College was removed to its present quarters. The atlas and axis are held together by bony union. The odontoid process is not in its normal position, but nearly in the centre of the spinal canal of the atlas. From this, one would judge that in displacement of these bones the transverse ligament had been torn and the patient had lived at least long enongh for the bony union to take place, although the spinal cord must have been impinged upon to a very great extent.

### NON-RECURRENCE OF MALIGNANT MAMMARY DISEASE AFTER EIGHTEEN YEARS.

Dr. Thomas G. Morton presented a patient, fifty-six years of age, on whom eighteen years ago he had removed the right breast for malignant disease; the tumor, a rapidly growing one, was large and with the usual characteristic symptoms. Since the operation the patient has had no return of the disease, and continues in excellent health.

### DEMONSTRATION OF A NEW SURGICAL ENGINE.

Dr. M. H. Cryer exhibited an improved surgical engine, with its various shaped drills, burrs, trephines, and guards, used in cutting bone for surgical operations.

The drills are made with three spiral blades, giving them the appearance somewhat similar to a twist drill. The effectiveness of these blades is enormously increased by a spiral screw, forty-four threads to the inch, cut around the blades of the instrument. This device necessarily adds forty-four teeth to the inch upon the edge of each cutting blade. The individual teeth are so arranged with reference to one another that the cut made by one tooth is overlapped by that of the one next following. These instruments are used for drilling into bone and opening the medullary canal, as in the case of osteomyelitis, or in removing sequestra formed in the long bones. After the bone has been cut down upon and the cloaca found, it is opened up wi h the spiral drill and by forcing the instrument laterally the side portion will cut the intervening bone away, thus making a groove down on the dead bone. If the opening thus made is not large enough, burrs of various sizes, made on the same principle as the drills by increasing the number of spiral tooth blades in definite relation to the size of the cutting instrument required, can be used to enlarge the groove to any desired size. These burrs are very useful for removing dead or abnormal bone, uncovering nerve canals for operating on the bony structures in relation to the ear, or in the nasal chamber. For the latter work, Dr. Cryer exhibited a lighter engine made on the same principle as the large one, except that it is made to turn by the foot of the operator.

The most important instruments exhibited were those used for making a section of the brain case. These were of two characters, the circular saw and the spiral osteotome.

The circular saw is one inch in diameter and one-sixteenth of an inch in thickness, having a guard attached to the end of the handpiece to regulate the desired depth to be cut. This instrument has been successfully used in an operation for the removal of the Gasserian ganglion. It cuts with great rapidity, but as brain cases vary in thickness, the operation has to be completed with mallet and chisel. The spiral osteotome overcomes this objection, the cutting portion being made on the principle of the drills already described. It is one-half inch in length, one-eight of an inch in diameter. The point of the instrument when in use is guarded by a rounded button-like attachment connected with the nose of the hand-piece by means of a shank and collar. The free end of the burr is dowelled into a seat in the guard in which it revolves; this steadies the whole instrument when in use, giving added rigidity to the burr shank and holding the burr and guard in permanent relation to each other. The principle involved in the instrument described is simply that of saw cutting in a line with the axis of the shaft of the burr and not at right angles to it as in the circular saw. Such an arrangement allows of cutting in any direction and upon curved lines. This is especially valuable in resection of the brain case, inasmuch as fenestræ of any desired shape or size may be speedily made.

In operating for the removal of a portion of the brain case with this instrument after a division of the soft tissue by the scapel, an opening five-sixteenths of an inch in diameter is made by a trephine mounted in the engine hand-piece; it is passed completely through both tables of the skull and a button of bone removed. There is no danger of injuring the dura with the trephine if it is carefully used. The opening thus made affords a means of entrance for the osteotome, which, with its protecting guard, is next inserted and the section made along the line previously determined by running the engine at a high rate of speed and forcing the bit laterally in the direction desired. The button-like guard at the point of the osteotome prevents injury to the dura, which is pressed or directed away by it from its attachment in the line of the cut as the instrument progresses.

Dr. Cryer made several demonstrations on the bones and head of the cadaver, showing the rapidity with which bone could be divided, and various operations performed, such as drilling and cutting bone, and uncovering the nerves in the superior and inferior maxillæ. The safety with which the operation in opening the brain case was done without injury to the dura was very gratifying. In conclusion he said: "At a meeting of the Philadelphia County Medical Society, held February 14, 1894, during the discussion of an operation for the removal of the Gasserian ganglion by Prof. W. W. Keen, in which this engine had, in my opinion, been successfully used, Dr. John B. Roberts made the following remarks: 'With regard to this elaborate instrument it seems to work very satisfactorily, yet for my own work I should rather use a sharp chisel with my own hand and my own mallet than any mechanical device. These are apt to get out of order and must be at some place where they can be kept in order. What we want to do is to train our own hands to do the work, and not to be dependent upon any mechanical device.' This statement indicates to me an erroneous position with regard to this class of instruments, which it seems to me ought not to go uncorrected.

"With all due respect and admiration for the ability of Prof. Roberts, I am a little fearful that surgery would take a back seat if all its mechanical devices were done away with. I heartily agree with him when he says: 'What we want is to train our hands to do the work,' and I would strongly advocate the highest possible attainment of manual skill as a necessary prerequisite in the performance of all surgical operations; but when he adds that we should 'not be dependent upon any mechanical device,' I am inclined to take issue with him on the ground that his statement is contradictory from the very fact that he himself advocates the use of a mechanical device, albeit a very crude one, in the shape of a mallet and chisel. This machine has now been so simplified and perfected that there is little or no danger of its getting out of order. It is not nearly so complicated as the most simple sewing machine, yet men and women run this, and who would say go back to the ordinary needle and do away with the sewing machine?"

DISCUSSION.

Dr. L. W. Steinbach: I have had the pleasure of having Dr. Cryer perform one of these operations for me recently in a case presenting some difficulties from the fact that repeated operation had been performed on the inferior maxillary portion of the fifth nerve, and I was delighted with the working of the engine, so far as the bone-cutting was concerned, but I do believe that the amount of blood lost was greater than at the previous operations, where the ordinary chisel and mallet had been employed. As a mechanical device I can praise the instrument, and I do not wonder that Dr. Cryer is enthusiastic, but I cannot agree with him that it is a great advantage to a surgeon to learn to use such a complicated machine. It might be of much advantage in a hospital where much work is done.

Dr. Roberts: I was very much interested in trephining with the surgical engine some

fifteen years ago, and wrote an article on the subject after experiments with a flat-headed burr. I am now very fond of the chisel and mallet for opening the skull, using a small sharp chisel shaped like an osteotome.

DR. J. WILLIAM WHITE: I have never had the advantage of seeing this particular instrument used in actual operations, but I can see no theoretical reason why it should not be employed with great advantage to surgeon and patient. I suppose there is no surgeon who does more trephining than Mr. Horsley, of London. I noticed last summer that he employed a powerful electric engine in which he used a burr or saw, and could cut out a section of bone with a great saving of time. It looked to me like a dangerous thing, and it was remarked that there was force enough to drive a part through a man had any portion broken loose. With it, however, he greatly reduced the time required for exposing a brain tumor, did the work with great delicacy and with much less shock (if shock is the result of jarring and concussion of the brain) during the operation than would be inflicted by a mallet and chisel. He, however, cut from without inward. This is the first time I have seen a machine cutting from within outward. We have observed here that it actually pushes away the artery from the bone without injury. I cannot understand why such an operation should be attended with any more loss of blood than by the usual methods, and I do not know why Dr. Steinbach's operation should have been any more bloody. Of course this view is purely theoretical, but as I find a surgeon like Horsley, who is one of the most expert operators on the skull, usuing a machine which seems to me of distinctly less advantage than that the action of which we have just had demonstrated, I believe this engine has a future especially for use in the hospitals, either for nerve resection through bone or for work upon the brain.

DR. M. H. CRYER: I have not much to say, for the demonstration was the principal part, but I am inclined to answer my friend Dr. Steinbach. I believe, from my experience and the experience of others, that in second, third, or fourth operations on the same part one generally has more hemorrhage, for the simple reason that the small arteries are dilated, small capillaries have become arteries through ligating the primary artery, and are therefore more difficult to control.

As to the engine getting out of order, the liability is very slight. It can be run by a child. It is much more simple than the sewing machine, and I should pity the doctor who cannot use this engine. Of course, every device placed upon it makes it a little more complicated, and it requires study and practice to know how to work it. But if I had to remove a portion of the brain case I would not think of using any other instrument at the present time.

## THE MARRIAGE OF SYPHILITICS.

By Wm. G. Porter, M. D. (See page 699.)

### DISCUSSION.

DR. J. WILLIAM WHITE: The general conclusions of Dr. Porter's paper, I think I, in common with all the members of the College, agree with. The three forms he mentions are commonly met with in practice. It is certainly to-day more benign than when many of us began to practice medicine. It is now rare to see the grave variety in which the primary symptoms are soon followed by the tertiary phenomena. If it is true that syphilis is a milder disease than it used to be, it is milder probably in every direction, and we may feel more encouraged than our predecessors to authorize the marriage of syphilitics. It was many years before Dr. Agnew could be brought to say positively that he approved of the marriage of any of his syphilitic patients, and it may be that this slowness on his part was due to the sort of experience with syphilis that we younger men had not had.

It is desirable to formulate some safe rule as to the permission which we are asked to give or withhold in cases of syphilitics intending marriage. Now, the writers who say that as we do not know when a given patient is cured, and as we cannot apply any test which establishes this, we cannot, therefore, give our consent, confuse the future danger of the individual with the possible danger to others, including his offspring. I think it is a confusion which prevails to a certain extent in the profession, and, to a very wide extent in the laity. It is unfortunately true that we are not able to tell a man that he himself will not have further symptoms of syphilis. We may place the percentage of cures very high, and I, myself think, that most of us who treat syphilis intelligently get from 90 to 95 per cent. of cures in the average line of cases. But we cannot select from the 100 cases the five or ten cases that we have failed to cure, and forbid marriage. Nor can we expect to do so until bacteriology has done more for us than it has up to the present. But that has very little bearing, I think, on the question of marriage. Because, as a matter of fact, after a certain time has elapsed, particularly after the combination of circumstances which exist where a patient has had moderate syphilis with efficient treatment, and has gone for a time, two years, say, without symptoms, I think we are very safe in saying there is little danger to others. Personally, I would have the same, but no greater, objection to giving my

consent to the marriage of a man with tertiary syphilis as to that of a man with strongly marked tubercular predisposition, or with mental disease. I think the risk of transmission in the two last named would be far greater than if he had gumma, rupia, or periosteal nodes. I am not aware of any instance, satisfactory to my mind, in which teritary syphilis has been transmitted either to any individual or to offspring. The reported cases are generally defective in some important point. It is difficult where two persons are concerned, particularly in instances of heredity, to be quite sure that the husband has been the parent, and most reported cases are at least open to error in that respect. There are other sources of error, but as a matter of fact, the impression left on my mind is that there is no case scientifically conclusive as to the transmission of tertiary syphilis. I would therefore dissent absolutely from those who believe that no patient with any form of syphilis should be permitted to marry. A man with tertiary phenomena is not likely to have healthy children, nor is the tubercular patient, but the man with tertairy phenomena is not likely to have syphilitic children. And it is safe to say he cannot transmit his disease. Even the fluid of his gumma, or ecthyma, or of his softening node, cannot be inoculated.

His wife may have an occasional miscarriage, or have a child born dead, just as might happen if the husband had chronic alcoholism, or was in the last stage of any grave constitutional disturbance, but she is not likely to have a syphilitic child. That, I believe is the only point in Dr. Porter's remarks on which I have any criticism to make. I think his general rules are admirable. It will surely not do to say that all syphilitics may not marry, because it would certainly result in ruining many lives. I am personally familiar with a great many cases in which unnecessary dread of syphilis has led to prolonged dissipation or melancholia, or suicide. I am now treating a gentleman who has broken off his engagement with an attractive girl; he has given up his business, and is gradually progressing toward the suicidal stage, because he is of the opinion that no man has a right to marry with this disease. He is morbid, of course, and I think he will probably come out of it. But there has no doubt been a great deal of unnecessary alarm. The rules of Dr. Porter are practically those I have adopted, except that I do not require such a long period of freedom from symptoms. In general figures I tell my patients they must wait four years. But if a man at the end of three years has a slight mucous patch I do not, on that account, make the time five years. For fifteen or eighteen years I have been seeing a great many of these cases, and I have from the start followed this general rule. Fournier's book was published about 1878, and was the first well-considered work on the subject which came under my notice. I had been appointed a teacher on syphilis in the University, and I practically adopted his rules then, and have never varied very much from them since. He said in effect that syphilis must have been benign; that a period of three or four years must have elapsed; and that the treatment must have been thorough and complete. I say I have never varied much from them, but as time has gone on I have come to place more and more weight on the one element of time, the period that has elapsed after inoculation, and comparatively less upon the throughness of treatment and absence of symptoms. And I need scarcely say that in that time there have been a great many patients grown up and married, and had children, and I cannot recall an instance where such marriage was entered into with my consent and approval where anything happened to cause me to regret my action. I do not know a single case where, after four years had elapsed before marriage, there was born a syphilitic child. I think that, after all, is the most important thing to discuss. If it is a safe rule, it is an easy one, and we cannot go far wrong in its application. If it is not a safe rule I shall be glad to hear reasons for considering it unsafe.

DR. EDWARD MARTIN: This subject has been very thoroughly traversed by Dr. Porter, Dr. White, and others. The rules governing it are practically common-sense rules dependent upon certain generally accepted facts: Thus every one grants that a man with syphilis not two years old is liable to give the disease to his wife, and to have diseased children, though this is a rule with many exceptions. It is also granted that a man with syphilis three or four years old is *not liable* to convey or transmit the disease; though this rule has a few exceptions. It is granted that a man with syphilis more than four years old is not necessarily cured, since it is impossible to state positively that late manifestations will not appear, but in so far as conveyance of the disease to others is concerned, he can be regarded as safe. This is a rule with very rare and doubtful exceptions. All the reported cases are open to the criticism of Dr. White. The evidence is, however, rather strong to the effect that the disease can be transmitted to the child when it is impossible to directly infect the wife. Finally it is granted that syphilis is a curable disease, though there is absolutely no sign or group of symptoms which can be taken as satisfactory evidence of cure. Reasoning from these rudimentary and commonly accepted beliefs it would seem perfectly proper

to allow syphilitics to marry after their disease has become non-contagious. Probably after two years of continued careful treatment the disease ceases to be contagious in the majority of cases. Not always, however, and it is proper to err on the safe side. The period of four years is that generally allowed, and I have never known a physician who has seen or heard of a case of transmission after this period. Even after four years marriage may not be advisable, not because a patient has had syphilis, or is liable to infect others, but simply because of debility or cachexia there is little promise of healthy offspring. The ground for forbidding marriage would be precisely that taken in the case of consumption. There is an exception which I have made to the general rule of forbidding marriage until the contagious stage of syphilis is passed. Although marriage, perhaps, had for its cardinal purpose, and has still, the propagation of the species, there are many other reasons why it is entered into. There is the element of association, protection, and mutual interest which can be considered quite aside from the sexual aspect of the case. It happens, I think to almost every one, to see cases of buccal chancre acquired by innocent girls from their affianced. I have never hesitated under such circumstances to encourage marriage, warning the patients thoroughly of the dangers of conception, until at least four years shall have elapsed. With this one exception I believe I am thoroughly in accord with the rules laid down by Drs. Porter and White.

DR. ARTHUR VAN HARLINGEN: The remarks I have to make are based only upon my own personal experience. Any man practiced in this class of disease, if he has kept careful note of his cases, must have a certain aggregation of personal experience; and I think that when we bring this experience together it is of a certain amount of value. When the subject of this discussion was first brought to my notice I began to look up the literature, and found that Fournier's work is practically the only one which could be used for reference. In an article written several years ago I based my observations on the work of another French writer, Lancereaux, which I thought excellent from a practical point of view. Fournier, however, is the only author who has given us statistics upon which we can base any conclusions. Aside from this, I think our individual experience is all we can depend upon. The result of my experience is as follows:

In my opinion, it does not seem proper for a man to marry as long as he has any of the secondary symptoms, though I have known immunity to result even in these cases. In my own experience, tertiary symptoms never prove contagious. The man who marries with the secondary symptoms runs the risk of conveying the disease to his wife. With tertiary symptoms I cannot recall any cases in which a man has given syphilis to his wife. In regard to the conveyance of the disease to the child, it has been said it is possible for a man who is in that stage in which the lesions are in all probability not contagious to convey syphilis to the offspring, but I cannot remember any cases in which this has been actually reported. I think it would be advantageous, if any such cases exist, that they should be recorded. Fournier records sixty to seventy cases of syphilitics who married at periods extending from nine to twelve months to a number of years. He reports one case in which the man having syphilis married, and after having three or four healthy children, he himself suffered from tertiary symptoms. His wife was not infected. My own experience is this: I have watched a couple of dozen of cases; I have followed some from five to twenty years, and I should not fear any of my patients marrying after the second year, if they have submitted to a regular course of treatment. I have been in favor of the continuous treatment. My custom has always been to wait until the secondary symptoms occur, and treat continuously. I have treated a dozen or twenty cases from eighteen months to three years. I cannot remember any case in which I have authorized marriage after the second year where the disease has been transmitted. I am aware that this is a much shorter time than is allowed. My own experience is that after the second year healthy children can be engendered. Perhaps the standpoint taken by others is a safer one than that I have taken. I think it will not be very long before some such question will come up before one of our courts of justice. It seems to me a question that we can only decide by uniting our experience, and by each person in private practice publishing his own well-recorded cases. And my urgent advice is that those who see such cases should record and publish them. I cannot see any other way of securing proper data.

I remember the case of a young gentleman who showed the late ulcerative symptoms of syphilis, which yielded very quickly to proper treatment. After the ulcerative lesions had passed away he suffered from that peculiar form of myositis resulting in the contraction of the biceps, which yielded some extent to treatment, but not entirely. He always had a certain amount of contraction. After eighteen months of treatment he asked me if I would allow him to marry. I said I would think it over for several months and then give him my opinion. He did not come back for that opinion. But if he had, and if I had given my consent, the case might have

been brought up before the courts. I wonder what my position would have been if this gentleman had married; if I had given him a written opinion that he would in all probability not transmit the disease to his wife nor have a syphilitic child, and then if the worst had happened? What would have been the expert testimony given by my colleagues? I think that if we could get a body of personal experiences by the gentlemen who see these cases, accurately gathered together, we would have something to go upon. There is really nothing in print except this book of Fournier's. If a case, such as I have mentioned to-night, were to come up before the courts, I do not know what I would have to base my opinion on, except what has been said here this evening. I think it is one of those questions in which the members of the college should publish their opinions, and this, I think, would make a body of evidence which would be of use later on.

DR. HENRY W. STELWAGON: I have listened with a great deal of interest to the reading of Dr. Porter's paper and the remarks by the other gentlemen who have spoken. It is a subject, of course, of large importance and far-reaching. It seems to me in a question of this kind an opinion is to be reached only after viewing it in all its aspects and bearings, basing the conclusion upon aggregate observations, and not putting too much weight upon individual experience. There are certain facts upon which I think all observers are fairly well agreed. One is that during the active and early stages of the disease marriage is tolerably sure to be followed by dire consequences. Another is, that under the most favorable circumstances at least two years should have elapsed between the contraction of the disease and the assumption of the marriage state. Another is, that after a variable number of years syphilis tends in almost all cases, and probably sooner or later in all cases, to lose its infective activity and transmissibility, so that finally there remains nothing of a specific character to transmit. This length of time depends doubtless upon several factors: the type of the disease, which Dr. Porter has referred to; the prior and concomitant health of the individual; his mode of life; and last, but probably the most important of all, the character and thoroughness of the treatment. In syphilis of a grave type, those cases which we see from time to time of a more or less malignant character, the greater possibility of present and future risk should not be lost sight of. The same can be said of the disease occurring in strumous individuals and in other persons in delicate health. The syphilitic addicted to the excessive use of alcohol for a longer time, is doubtless an unsafe husband and procreator. The explanation is to be found in the lessened resisting power. With the exception of these several classes, however, I believe that syphilis is not the grave misfortune it has so often been painted. In the average case of syphilis, occurring in a subject of ordinarily good health, living a temperate life, and who has had intelligent treatment, the power to communicate and transmit the disease is probably, with the exception of a few instances, lost in the course of a few years; and even in the imperfectly treated and neglected cases, judging by general experience, the disease would seem to wear itself out in from two to five years. If this were not the fact, the example of hereditary transmission would certainly be much more numerous than observations show them actually to be. It is, however, the uncertain cases, or the exceptional cases I would say, which give us concern and make us hesitate. And such cases, we are informed by the records, may occur in those who have been well treated and carried out all medical directions, and who are or should be presumably entirely free from all contaminating virus. That such exceptions, according to the records, do occur we must all concede; that they are extremely rare must likewise be granted. It has often occurred to me that some of these exceptions are apparent rather than real, that there may have been good and sufficient reasons pointing against marriage, such as an insufficiently long period of treatment, depraved general health, alcoholism; some may also be attributed to faulty observations, as Dr. White has suggested. I believe myself that persons in good health, of good habits, in whom the disease has been of a mild or average type and has run a favorable course, with no tendency to active recrudescence, and whose treatment has extended over a period of two or three years, during the last year of which there have been no manifestations—that such persons may, if three years or more have relapsed since the date of the contraction of the disease, marry without the slightest risk. Such is the conclusion to which my own observations would lead.

If, however, the question of the marriage of syphilitics is to be viewed purely from a strictly scientific and medical standpoint, and thus necessarily taking cognizance of the rare exceptions and recognizing the possibility of disaster, we should probably feel obliged to refuse our professional permission in all cases. But by so doing we would prevent many happy marriages, damage the socially and politically important family life, and tend, moreover, to encourage immoral living. A liberal view of the question, based upon the broad ground of the public welfare and the knowledge that in proper cases the danger is practically *nil*, would not justify us in such a course.

DR. A. B. HIRSH: There is one phase of the subject which has a half-medical, half-popular aspect, that might be appropriate to mention here, and I refer to a point raised in the discussion by Dr. White, that of syphilomania as occurring in some of the chronic cases coming under our care. We are quite well aware that such cases are apt to occur in the intellectual patient, the man who reads, and not in the average or ignorant dispensary class; such individuals would be apt to have this subject laid open to their inspection by novelists who deal with the more material subjects of the day. It is quite interesting in this connection to know that one of the works which has been most widely read recently deals with this very subject, and individuals suffering from this infection and reading the same would perhaps be confirmed in this very serious view of the subject, and be liable to the mania here discussed.

DR. PORTER: Dr. White seemed to intimate that I possibly thought the tertiary lesions were contagious. I had no such thought at all, and put tertiary patients under the bann, not on account of their generally broken down condition of health, which would not justify marriage.

In regard to the time, the rule which I laid down which has guided me for a number of years is to allow two years to elapse after the disappearance of the last syphilitic symptom. The average period of the duration of treatment is about two years, and that would make the duration the time laid down by Fournier, four years after the inception of the disease. Many cases, however, do well in which the treatment is not prolonged more than a year. At the end of that time, after two years have elapsed, that would make the period three years. The time depends on each individual case.

In regard to statistics, Dr. Van Harlingen has well said that the only thing we know of in the literature on this subject has been written by Fournier, and these statistics, as well as those given by other writers, are very misleading, because it is only within comparatively recent years that syphilis has been so systematically treated as it is to-day, and certainly many of the cases of alleged reappearance of symptoms many years afterward could be explained on the ground of insufficient treatment. I think that statistics could be collected of the modern methods of treatment of syphilis that would show much more favorably than older statistics.

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"WHAT did he strike for?"
"Eight hours."
"What did he get?"
"Three months."—*Judge.*

## A Note on Tubercle Bacilli in House Dust.

From *The British Journal,* by R. Shalders Miller, M. B., F. R. C. S. He made an interesting examination of the dust in a house where there had been a series of cases of phthisis.

About fourteen years before the date of making the examination, a man affected with phthisis lived in the house, and left it only a short time before his death. After this an old lady lived in the house for six years, and died there; but not of phthisis.

Then a family consisting of a lady and five daughters took up their residence there; four of the girls being at school most of the time.

In a year the lady became a victim of phthisis. She lived for three years, and then died of the disease.

During her illness the oldest daughter showed symptoms and signs of this disease, but went away from home for a short time, and then returned apparently well, and has remained so.

A few months after the mother's death the second daughter, who had not long left school, displayed similar symptoms; but on leaving home for a time, fortunately made a complete recovery.

In January, 1892, the third daughter, who had left school only at Christmas, and had been suffering from a severe cold, showed consolidation of the apex of the left lung. This girl was not strong, and having had bronchitis when young, the disease advanced rapidly and soon proved fatal.

On several different occasions specimens of her sputum were stained, and showed an ever-increasing prevalence of tubercle germs. Several samples of dry dust, six in all, were obtained from various parts of her home. Of these six samples, five were ruined in the course of preparation. The one still remaining was scraped off the top of the dining-room door. It showed no fewer than eight groups of bacilli, and one of these groups numbered several hundred germs.

After this the house was fumigated and then vacated.

Similar observations have since been reported by a Paris physician.—*Med. Mirror.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE ARCHIVES OF PÆDIATRICS

for May. Dr. P. B. Bennie has a paper on

**Growing Pains,**

which term he criticises, saying that as his experience increased he made the diagnosis less and less frequently, and found that cases formerly so classified were myalgia, rheumatic fever, occasionally typhoid fever, tubercular arthritis, or adenitis, or some similar disorder in which the pain was so acute that the attention of the patient and friends was attracted to it only.

In many cases a child playing out of doors exhausted itself, and the sharp pains complained of were due to retained products of muscle waste, and readily relieved by favoring the return circulation by elevating the limbs, for a few minutes, and stroking them briskly toward the trunk.

Dr. Charles G. Kerley gives his experience with

**Acute Bronchitis in Infants.**

A large part of the author's observations was among hospital cases, and the general health had been poor, and called often for the continuous use of cod-liver oil, after recovery from the acute disorder.

The treatment advocated is as follows: Ventilating the sick room and keeping it about 70° F., flannel next the skin, and discarding the universal belly-band; frequent changing of position to avoid hypostasis, bathing with lukewarm salt water, preferably at night.

When dyspnœa, hard tight cough, etc., exists, the author advises a steam spray and the use of a sheet wet in hot mustard water (100° raised to 110°), once daily to wrap the child in.

The author believes the spray, and counter-irritation (by mustard paper, camphorated oil, turpentine, etc.), much more useful than internal medication.

A few drops of castor oil are sometimes used at the outset, or a tablet of 1-10 or 1-20 gr. ipecac, with 1-50 to 1-80 gr. tartar emetic hourly; strophantus, or whiskey, occasionally for cardiac weakness, and, in cases of restlessness, bromide, chloral, or Dover's powder in small doses.

Dr. Henry W. Berg writes about the

**Recent Epidemic of Cerebro-Spinal Meningitis.**

The disease is, he says, constantly present in New York; but, during 1893 many more than the usual number of cases appeared. Among the facts of interest noted by him are: That most of the cases occurred in children under five years of age (the rule, he says, in all epidemics); at the time meningitis was most prevalent, pneumonia was also very common, and the diplococcus of pneumonia was one of the most constant of the organisms found in the exudate.

The greater nervous irritability of children is a sufficient explanation for their being more frequently affected than adults. Two members of the same family are rarely attacked, and it is considered safe to treat cases of meningitis in the general wards of hospitals. Bad hygienic surroundings predispose to the disorder, and in other respects the localities infected seem often to have very little connection with each other, a large area of country never being affected, but rather small areas, wards or parts of wards in a city, etc.

In describing the symptoms of the disease the author divides them into—those due to the poison of the disease; those due to inflammation of the cord and its membranes; those due to inflammation of the brain and its membranes.

Cases may die in a few hours, or days, or may last some time, and perhaps recover with serious sequelæ.

Pains in the muscles, etc., occur here as in other fevers; also vomiting, so that the pathognomonic symptom is the cervical rigidity, which may by a jolt or start become a true tonic spasm.

Headache is usually present, so also is fever; but either may be absent, and the author reports a case dying without a temperature at any time above 100.°

The only symptom the author lays unusual stress on is the nasal catarrh, he regards this as a probable explanation of the disease, the patient becoming infected through the nasal passages, and a meningitis developing, owing to the pneumococcus, instead of a pneumonia, and he thinks that in this we have the reason for cerebro-spinal meningitis following influenza.

Eye lesions, the author found rapid in development, and of serious grade.

Dr. George Carpenter reports a case of "Diphtheria from Decomposing Placenta."

The explanation of the curious title is that two weeks after a careful antiseptic delivery the patient developed fancial diphtheria, and, as all sanitary arrangements, etc., seemed of the best kind, all concerned were puzzled to account for the trouble, until a commode was opened and found to contain the placenta, badly decomposed.

Dr. John Thomson (Edinburgh) reports a case of a child contracting "Tænia Circumerina from a Pet Poodle."

Dr. W. C. Cole, of Jacksonville, Ill., describes a case of "Fatal Diphtheria in a Child, Contracted from a Chicken."

THE SANITARIAN,

for May, contains an article by Dr. Wolfred Nelson, on

**Dangerous Practices on the Isthmus of Panama.**

The writer states that it is customary to hire a coffin to carry a corpse to the place of

burial, where the body is removed and buried wrapped in its shroud, and the coffin taken back to the undertakers. Another plan is to rent a burial niche in a building of stone, and so long as this rent is regularly paid the coffin is undisturbed, but as soon as it is overdue "an eviction is in order" and the coffin and contents dumped in a pile, which is burned when its size becomes too great. Still another plan seems to be to reopen a grave and bury another body in it as often as possible; the author having a record, showing that a certain cemetery had been dug over four times in five years.

Other articles in this number are: H. W. Wiley, on

**The Adulteration of Food,**

in which the author uses the saying of Barnum, that "Americans like to be humbugged," as showing one reason why food adulteration is permitted to continue. The author thinks people would frequently rather pay a higher price for an adulterated food sold as pure and of high grade than for the same food sold with the statement that it is an imitation of a really pure article which sells at a price still greater. On this principle he thinks we may explain the reason why persons not directly interested in their sale do not seem eager to have such articles as oleomargerine stamped with a distinctive name when exposed for sale.

The author speaks of adulterations, which make the article sold less useful as food, although not of necessity injurious, and those that are imitations of a more expensive but not necessarily more nutritious or more palatable food.

Very interesting notes are given of the different state laws on adulteration, misrepresentation, etc., of foods, the manner in which these are enforced, and also of the fallacious ideas people in general have of what the most common adulterations are, and to what extent they are carried out. Mention is also made of the uselessness of laws against adulteration which do not provide for careful inspection of samples, and constant supervision by government inspectors.

Under the title

**The Need of a National Health Service,**

the petition of the American Medical Association for the establishment of a Department and Secretary of Public Health is given and discussed at length. The objects to be attained by this department are shown to be not only the prevention of contagious and infectious diseases, but also the supervision of certain industries so as to prevent, or lessen, the occurrence of such nervous troubles as writers' and telegraph operators' palsy, mental disorders of overworked mail clerks, and many others.

From the *Nineteenth Century* is taken an article on "Women as Inspectors."

The article refers to women as members of committees of poor-house inspectors, and snows the result of experience in England in this line. Women are certainly more competent than most men to decide whether the bedding and household utensils are in good condition, and whether or not certain household duties are properly attended to, and since their admission as members of certain boards great improvement has followed their suggestions and supervision.

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THE VIRGINIA MEDICAL MONTHLY

for May. Dr. Joseph A. White contributes a paper on

**Foreign Bodies in the Air-Passages;**

(nose, pharynx and larynx). In speaking of foreign bodies in the nose and the frequent ineffectual attempts made by the unskilled to remove them, the author says there is no need of anxiety about a foreign body being in the nose, nor of these clumsy attempts to extract them. There is no immediate risk nor danger from its presence, and no occasion for hurry about removing it, if one has not a knowledge of the proper methods and a suitable instrument to use. As a rule there is even no discomfort. The only possible dangers are that a small smooth body might, under some circumstances, be drawn through the nostril, and, by a sudden inspiration, pass into the windpipe; or a rhinitis, sometimes of an offensive character, be set up by any lengthened retention of some foreign bodies. Any physician can easily remove foreign bodies from the nose, even when apparently tightly wedged. A spray of a solution of cocaine will sometimes shrink the tissues sufficiently to loosen it, and gentle traction with a bent probe remove it. The nasal douche, properly used from the nostril opposite the one containing the foreign body, frequently brings it out in the flow of warm water.

In regard to foreign bodies in the pharynx the author states that their removal is an easy matter unless they have passed down to the lower third or into the œsophagus out of the domain of the air-passages. A weak solution of cocaine will relieve all the uncomfortable symptoms.

Foreign bodies in the larynx are more serious than in the nose or pharynx, because of imminent danger of suffocation, if it is not speedily removed, or of secondary troubles from its retention that might cause death. The plan followed by the author is to deaden the pharynx with a 2-per-cent. solution of cocaine by a spray-producer, and then apply a 20-per-cent. solution very thoroughly to the larynx with a brush. He has never been able to do away with the reflex spasm of the larynx with a weaker solution, and sometimes he has had to repeat this application several times in order to do this. In this way he has removed pins, bones, etc., from the larynx without any discomfort to the patient. Sometimes foreign bodies can be successfully removed from the sub-glottic space in the same way. Usually, however, when it has passed into the trachea, if the method of inversion fails, or is impracticable (and it usually is only useful when the foreign body has weight enough to be acted on by gravity, such as a coin), trecheotomy becomes necessary. Even if a small body, such as a grain of corn, or some such substance, has passed into a bronchus, it may be coughed out,

when the trachea is opened, in the first rush of air. If it is not thus expelled, many devices are suggested to remove the foreign body, after tracheotomy, but they may or may not be successful. Its retention in a bronchus may be followed by tolerance for awhile, and subsequently expulsion, of which there are many cases on record; or inflammatory troubles may supervene that will cause death sooner or later.

**Poisoning by Illuminating Gas**

is the title of a paper by Dr. John W. Shaw. The author believes that it poisons in three different ways:

First. By the gas replacing, to a greater or less extent, the atmospheric air, consequently reducing the supply of oxygen.

Second. By the direct poisonous properties of the heavy and light carburetted hydrogen, when mixed with air and absorbed through the lungs.

Third. By the collection of carbon dioxide in the body for the want of sufficient interchange of gasses necessary to remove it.

Which of these plays the most important role in destroying life, the author is unable to say, but he believes that the retention of effete material generated in the body itself is the principal poisoning agent; in reality it is poisoning from the effects of carbonic acid gas, and not illuminating gas. In the treatment the author does not think the inhalation of oxygen has any advantage over a plentiful supply of fresh air. The author thinks that transfusion of blood, when practicable, would be the most rational form of treatment in extreme cases, for it immediately supplies the system with hæmoglobin, of which it is in such great need. This, combined with fresh air, artificial respiration and stimulants, in the form of hypodermic injections of nitro-glycerine, constitute the principal points in treatment.

Dr. Llewellyn Eliot discusses

**The Treatment of Hemorrhoids by Injection.**

The author reviews the various forms of hemorrhoids and the treatment of them by palliative measures. External hemorrhoids may be relieved by the use of laxatives with the application of an ointment or suppository of extract of belladonna and opium, leeching, or a strong wash of tannic acid. Incising and turning out the clot, or a ligature applied, he states, is the generally adopted form of treatment. With internal hemorrhoids palliative treatment is much more unsatisfactory, though many cases are relieved for long periods of time by the use of laxatives, astringent injections, dilatation of the sphincter, and regulation of the diet and avoidance of alcoholic liquors. When hemorrhoids depend upon any disease of the uterus, an examination should be made, and any displacement existing be corrected before operative treatment is instituted. Hemorrhoids occurring during pregnancy sometimes demand operation; and while the pregnant state is not a barrier, it is safer to defer operation until some weeks after delivery. If internal hemorrhoids actually exist, palliative treatment will not cure them; operative treatment alone is what should be adopted. Before any treatment for internal hemorrhoids is adopted it is absolutely necessary that the bowels should be well cleansed. This may be done with calomel, sulphate of magnesia or an enema.

The author then proceeds to review the various methods of operating—the ligature, the clamp and cautery, injection of carbolic acid, crushing, excision, dilation of the sphincter, and Whitehead's operation. Of the treatment by ligature he says that it is the easiest of performance and safest in its results, and is generally accompanied with less pain than any other treatment. Excision is the operation for the expert only. Whitehead's operation is difficult, tedious, and bloody; and if primary union does not ensue, pus accumulates and makes an ugly result. It is therefore applicable to only a few cases. Dilatation of the sphincter muscles cures not so much from the dilatation, but from the fact that it puts an irritable sphincter at rest, for usually there is some abrasion about this muscle. In this condition great relief is felt by its employment.

In regard to the treatment by injection, the author says that notwithstanding all the testimony which has been brought forward against the method, he has never had a bad result from its employment. In every case where he has injected hemorrhoids, there has been a cure as permanent and positive as any result may be called a cure; the hemorrhoids have, as an invariable rule, disappeared, nor has there been a single recurrence of the tumor. The formulæ for the injection which have given him the most satisfactory results are: carbolic acid in glycerine and water of a strength of 12, 15, 33, 50, 95 per cent. To inject hemorrhoids it is necessary to draw them well down, using cocaine anæsthesia if desired; as the sphincter is well dilated this is an easy matter. The needle, not too fine or too sharp, is thrust into the pile and the solution driven in. The author has never limited the injection to a few drops, and has always injected all the tumors at one time. The pain is sometimes great, requiring morphia. Vaseline is freely used and the tumors returned to the bowel. Bleeding has never occurred. A slough forms in three or four days, and is cast off, when there will be found a clean surface with no evidence of a pile. In the cases which the author has treated, rarely has it been necessary for the patient to remain in bed more than twenty-four hours. Usually they are about their rooms sooner.

Dr. Joseph Jones contributes a paper on

**Diphtheria,**

the full title of the contribution being: "Personal Experience with Reference to Diphtheria in New Orleans, La., 1868–1894, also Progress of Discovery with Reference to Nature and Treatment of this Disease During the Past Twenty-five Years." In a former number of the journal the author gave a history of the disease as it has appeared at New Orleans and in this communication he confines himself to points of practical interest as to its origin, hygienic and therapeutic treatment. The author states that he has observed

certain facts which have led him to attribute the propagation, if not the origin of diphtheria, to the filth engendered by milch cows, and also to their milk, in dairies confined to the limits of the city. In support of this view he gives several cases from his records. He also states that he has witnessed cases of diphtheria in which there was no obstruction of the respiration by the diphtheretic membrane, but in which death seemed to result from the direct action of the poison on the heart, and the consequent prostration of the muscular and nervous systems.

The author believes that the Klebs-Loeffler bacillus is the causative agent of diphtheria, and that systemic infection by the diphtheretic poison is not produced directly by the entrance of the microbe into the circulation, but by the ptomaines which have been produced by it. He also states that the use of corrosive sublimate in this disease is not new as it was prescribed by Dr. Tappan in 1860–61. The author states that he cannot subscribe to the large doses and almost reckless manner in which this drug is used. On the other hand, the use of the sulphite and hyposulphite of sodium, in doses of one or two scruples every two hours, both as local and constitutional treatment of diphtheria, appears to be far more philosophical, and should be extensively employed and thoroughly tested.

Dr. W. E. Todd calls attention to the "grave evil that confronts us"—the medical profession—in a paper on

**Proprietary Medicines.**

The writer says: "Medical journals are more to blame for patents and proprietary frauds than the men who read them. With few exceptions, the journals are living from patent medicine pap, and that is why they are slow to raise their voices against the crying evil. I can name hundreds of the vilest patents that are lauded by reputable medical journals for their superior medical properties and their palatableness, when the publisher knows them to be arrant frauds. No wonder upwards of four hundred so-called medical journals can thrive in the United States." The author urges on the doctors of the land to write their own prescriptions and use staple drugs instead of trusting to patent and proprietary preparations.

Dr. C. E. Busey contributes a paper on

**Can Phthisis Be Prevented?**

The author believes that tuberculosis can be inherited and that a tuberculous mother can infect her fœtus with the bacillus present in her own system. In such cases hygienic measures will be of no avail, except possibly to so improve the general health of the child as by the physical vigor thereby established to eliminate the inherited germs of disease from the system. Beside the well-known precautions against infection from the sputa of phthisical patients the author can suggest nothing except the forbidding of marriage between persons who are susceptible to the attacks of the bacillus of tuberculosis by reason of their family history, until they shall have arrived at perfect physical maturity. This, the author concedes to be impossible.

Dr. Wm. A. Thom, Jr., contributes a paper on

**Chronic Bright's Disease,**

with special reference to the causes which produce it. After reviewing the causes of the disease as usually stated in the text books, the author states that he is of the opinion that mind strain from work, worry or sorrow, is a more prolific cause than all the rest. The author's theory is that the kidneys are the emunctories of the brain. The brain, in a constant state of exalted activity, requires the elimination of a quantity of phosphates so largely increased from the normal twelve parts per thousand as to become a "form of injurious matter." All of this work being done by the kidneys, they are then put to a strain under which they slowly break down and take on chronic inflammation and disintegration until they become useless. This action, which the author imputes to the phosphates, would be exactly analogous to that of the urates in the gouty causation of the trouble. The author thinks that this theory would, in a great measure, account for the increased frequency of the disease in late years. In support of this theory the author quotes a case, reported by Dr. E. G. Janeway, of a broker who has had trouble with his kidneys for years. It has been ascertained that when the patient's mind is at rest, albumen tests result negatively, while even the exertion of reading a newspaper will cause albuminous reaction at once.

In regard to the treatment, the author thinks that hygienic measures promise more than others. If alcohol is the cause, abstention from alcohol; if gout, the treatment of the gout; if the too frequent and great elimination of the phosphates, the avoidance of the causes which excite the mind or call for mental labor. Under all circumstances the most careful attention to the functions of the skin and bowels, avoidance of exposure to cold and dampness, and the enforcement of rest. The author has had more success from the use of bichloride of mercury than any other one remedy, though he cannot explain its action. Chloride of gold and sodium may also be useful since it is a tonic, produces sweating and salivation without the mercurial soreness, and is eliminated by the kidneys, where its curative action makes an impression on the connective tissue, and lessens or prevents its overgrowth. In cases where the uræmic symptoms cause emergencies, pilocarpin is probably our best remedy, on account of its rapid action on the skin, but it must be watched for fear the great salivation may become an obstruction to breathing. In this condition, chloroform and chloral are also useful.

**Varicocele**

is the title of a paper by Dr. Stuart McGuire. In regard to the treatment of this condition, the author is of the opinion that the milder forms should be met by palliative treatment only. The mental impression should be combatted by judicious encouragement and

the exciting cause of the trouble determined and removed, if possible. The constitutional tone of the patient should be improved by regulating the habits of life, the use of cold shower baths, and the administration of iron, quinine and strychnia. The scrotum should be supported by some mechanical device, such as a well-fitting suspensory bandage. These measures usually give relief, and may result in a permanent cure.

The author has employed the following operation in five severe cases, with uniformly good results: The scrotum, pubes and thighs are shaved, well scrubbed with soap and water, and irrigated with a bichloride solution. The vas deferens is isolated and slipped behind the other constituents of the cord, and the veins grasped and made prominent by the fingers and thumb of the left hand. An incision about an inch long is made over the cord parallel to its course, and the veins, covered by their sheath, exposed. By means of an aneurism needle, a catgut ligature is passed around the aneurism at the lower angle of the wound, and securely tied. The veins and their fascia are then freed from the surrounding parts for an inch or more above the ligature, and a second ligature passed around them at the upper angle of the wound, and tied. The ends of both ligatures are left long. The portion of the veins between the two ligatures is divided above and below, about a quarter of an inch from the ligatures, and removed. One end of each ligature is threaded on a needle, and passed through the end of the stump which it encircles, and is thus made to emerge at a point opposite the knot. After all bleeding is checked the two stumps are brought together and kept in accurate contact by tying the corresponding ends of the upper and lower ligatures together. The ends of the ligatures are cut short, the wound irrigated and dried, and the incision closed. The next step is the curtailment of the scrotum. The testicles are pushed up against the pubes, and the scrotum drawn through the blades of the scrotal clamp. The clamp is applied from above downward, and care should be taken to depress it well towards the perineum, and to have the raphe of the scrotum in the middle line of the condemned tissue. Interrupted silk stitches are now passed through the scrotum on the distal side of the clamp, and the redundant tissue cut away. The clamp is then removed, bleeding arrested, the stitches tied, and a dressing applied.

In none of the author's cases were there any complications, and the average duration of confinement to bed was ten days.

Dr. J. I. Darby discusses

**The Treatment of Traumatic Epilepsy,**

reporting several cases. The author states that the only remedies to be relied on in the treatment of traumatic epilepsy are the trephine in depressed fractures and the scalpel in other traumatisms which may produce reflex irritation of this character, and when the bone is removed in fractures, the dura should be opened, and if the cortex of the brain shows any signs of injury, it should be carefully cut away. When the bone is not cut away in small bits, it may be replaced in the opening and expected to cause no trouble, provided the button is not thicker than the surrounding bone. After surgical operations for this disease, the patient should be kept on medical treatment for at least two years to prevent a return of the trouble, and it is in this class of cases that we may expect good results. Bromide of potash, in full doses, has given the best results, but a solution of bromide of gold and arsenic has of late given very satisfactory results. The patient should be induced to live a temperate and systematic life, sleeping regularly, eating moderately, and keeping his digestive and excretory organs in a healthy condition. Especially is it necessary for him to abstain from the excessive use of tobacco and alcoholic stimulants.

The author urges on surgeons to prevent these cases by operating on all depressed fractures as soon as seen.

Under "Clinical Reports" there appears the report of a "Series of Twenty-five Abdominal Sections," by Dr. I. S. Stone. One death occurred, due to operation for long-standing pelvic suppuration. In this case the death was apparently due to the action of the ether given. Not a single ounce of urine was secreted during the twenty-four hours that the patient lived after the operation. The autopsy revealed a perfectly satisfactory state of the peritoneum, pedicles, etc. The time of the operation did not exceed forty-five minutes.

Dr. A. W. Bolling reports "A Unique Case of Twin Child-birth." There was an interval of thirty-six hours between the births of the two children, during which time the woman remained free from pain. The second child had been dead in utero for some time, as it was putrid. The woman recovered without any complications.

Dr. S. Walter Woodyard reports a case of "Spina Bifida; A Cure by Iodine Injections."

The remaining papers in this issue are:

"A Study of the Soil in Relation to Health and Disease," by George M. Kober, M. D.

"Outerbridges Wire Cervical Dilator for Obstructive Dysmenorrhœa," by Alexander Irvine, M.D.

"The Evolution of Empyricism in the District of Columbia," by J. S. McLain, M.D.

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### For Neuralgia.

For stubborn neuralgia try the following:

℞
Antipyrine..... 5 jss.
Caffene..... 5 ss.
Ext. Cannabis Ind.
Ext. aconite..... āā gr. ijss.
Hyoscyami hydrobromat..... gr. ½.

M. Ft. caps. No. xxx. Sig. One every two or three hours.

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### Elixir Five Chlorides.

℞
Corrosive sublimate..... 3 grains.
Solution chloride arsenic..... 3 drachms.
Hydrochloric acid, dilute,
Tinct. iron chloride..... āā 1½ ounces.
Ammonia chloride..... 3 ounces.
Elixir simplex.....to make 16 ounces.

M. Sig. Teaspoonful after each meal.

—*Medical Summary.*

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE

### Prognostic Aphorisms: Albuminuria (Warren.)

If albuminuria appears in the course of another affection and persists more than four weeks it is to be feared that albuminous nephritis will be induced and be irremediable.

The existence of albumen in the urine with a diminished amount of urea is a sign of bad omen.

There is but little hope if in the course of an albuminuria the urine is excreted in small quantity, especially if the diminution occurs suddenly.

When the suppression of urine is total (anuria) the end is necessarily fatal.

A diminution in retinitis is a favorable sign.

Amaurosis accompanied with encephalic pain announces a fatal end, imminent and inevitable.

Acute uræmia may cause death in four hours, but, as a rule, in three or five days.

The eclamptic form is less favorable than any other variety.

Microscopic study of the urine by revealing the state of the kidneys is the essential basis of prognosis.

In acute albuminurious nephritis the disappearance of hydropsy without corresponding disappearance of albumen in the urine is of grave portent.

Accidents are imminent if the abundance of albumen coincides with the diminution of the amount of urine.

Bright's disease is always fatal.

Scarlatina in its decline, accompanied with thoracic and cerebral complications due to the existence of albuminuria, is of grave outlook.

The same is true of albuminurious anasarca following measles.

Phthisis and bronchial dilatation are hastened in their course by the appearance of albuminuria.

It is one of the most terrible complications of scrofula and tertiary syphilis.

Erysipelas following in the course of albuminuria is almost always irremediable.

If in the course of a suppurating hematocele or some other chronic affection albuminuria appears the end will be accelerated.

Albuminuria often determines abortion or premature child-birth. If the child is born alive it often dies several days after of eclampsia.—*St. Louis Med. and Surg. Journal.*

### Some of the New Hypnotics for the Insane.

Dr. Granger, in a paper read at a meeting of the New York Neurological Society, said that those drugs were the best hypnotics, which act first and strongest upon the cortex, dulling the sensibilities and lessening voluntary muscular activity, and which influence but little the vascular system and blood pressure. Among the newer hypnotics he mentioned bromal hydrate; he said it was more dangerous than chloral and of but little value. Chloralamid he considered less depressing than chloral, although serious collapse had followed its use. It produces quite refreshing sleep, with no unfavorable after effects. It is not so certain in its action as chloral, and it does not act so promptly. The dose is from 30 to 45 grains. It is useful as an alternative to the other hypnotics. Chloral-ammonium, in doses of from 15 to 30 grains, is said to be non-depressive, and considered a good hypnotic. Hypnal has the reputation of uniting the analgesic effects of antipyrin and the hypnotic effect of chloral. It is useful when sleeplessness and pain are combined and the employment of opium is contraindicated. The dose of the drug is from 15 to 30 grains. Urethan, which belongs to the ethyl group, is useful in the milder cases of insomnia and for purposes of change. Its dose is from 20 to 40 grains. Somnal is an alcoholic solution of chloral and urethan, and of little value. The dose of somnal is 30 grains. Paraldehyde cannot be classed among the newer drugs. It is the only drug, aside from chloralamid, which is comparable with chloral in hypnotic power. These three hypnotics are valuable in all cases of insomnia. Sulphate of duboisin is used as a substitute for hyoscin. It has been said to give more natural sleep and to be less depressing. Sulphonal, tetronal and trional are so closely related that they may be considered together. The first mentioned has marked hypnotic power and seemed, in ordinary doses, to be safe. Its long continued use was, however, dangerous to health. Its action is often slow; it seems to be precipitated in the stomach unless quickly absorbed. Its effect is frequently long continued, the second dose often acting better than the first. It appears to be of little value where sleeplessness is associated with pain. Trional and tetronal are true hypnotics, but alike in many respects to sulphonal. They are all less powerful than chloral.—*Occidental Med. Times.*

### A New Cure for Hay Fever.

Fuber, of Hamburg, who suffered a great deal from hay fever during the summer, noticed that in winter a coryza was accompanied with hot ears, which regained their normal temperature when the discharge from the nose was established. He tried a reverse order of things on the hay fever, and rubbed his ears until they became red and hot. It is now the third summer he has led an endurable existence. As soon as there is the least amount of fullness in the nose, the ears are noticeably pale. A thorough rubbing of the ears has always succeeded in freeing the nasal mucous membrane from congestion. The rubbing must be thorough and repeated.

### Air Embolism.

In the nineteenth of a course of lectures delivered by Dr. David W. Cheever, Professor of Surgery in Harvard University, and published in the *Boston Med. and Surg. Journal*, we find the subject of air embolism treated of substantially as follows: One of the most distressing and rapidly fatal accidents that can occur in a venous wound is the entrance of air. It must be a large vein to admit it. It is sucked in in inspiration. That is the case in the larger veins about the neck, which have no valves, and is especially the case when the mouth of the vein happens to be held open after it is cut by being attached to a fascia, as about the neck, in the popliteal space, in the groin, etc., but especially in the neck. When, for example, the surgeon is engaged dissecting out a tumor in the subclavian triangle, everything is done more easily if the parts are on the stretch. They are out of sight and very probably displaced by the growth of the tumor. The vessels may be enlarged as well as displaced by the long-continued growth.

### Bromide of Gold and Arsenic.

Some months ago a physician of this city claimed to have discovered or invented or introduced a new solution of the bromides of gold and arsenic, published some remarkable cases as cured by the administration of the new medicine and secured a wide notoriety with the aid of some injudicious friends. Shortly after a firm of dispensing chemists in the east secured from this physician a monopoly of its manufacture, and advertised it to the medical world by circulars and pamphlets. The profession is under a great obligation to Mr. Bachmann for the publication of the working formula for the manufacture of this solution. We believe Mr. Bachmann to be the originator of what may be called its revival, and of course he speaks *ex cathedra*. This publication effectually exposes the trade secret which has allowed of a monopoly in manufacture, and puts the preparation within the reach of any skilled pharmacist. The advertised solution is sold for one dollar an ounce. The cost of the ingredients in a gallon of it is less than five dollars, leaving a profit of more than one hundred and twenty dollars on every gallon. If it is as therapeutically valuable as is claimed (which we doubt) Mr. Bachmann has conferred a lasting benefit upon us.—*Pittsburgh Medical Review.*

### Treatment of Eclampsia.

Tarnier (*Journ. des Sages-Femmes*) maintains that eclampsia represents a true poisoning of the blood. It is not caused by retention of urea or carbonate of ammonia in the blood. In eclampsia the blood is absolutely poisonous, as experiment has shown. On this account Tarnier holds that blood must be abstracted in a case of puerperal eclampsia. But then the patient would have less blood (and loss of blood is a great evil under the circumstances), and that blood would be as poisonous from the first as the blood removed. Hence the advantage of a milk diet, which is, to a great extent absorbed, so that the blood becomes diluted, increasing in bulk, with diminution of the proportion of poisonous material. Free purgation is also desirable for ensuring elimination of poison. Tarnier gives croton oil. Inhalations of chloroform are also beneficial; they calm the nerve centres, which are excited by the circulation of poisonous blood, and thus check, in a direct manner, the tendency to convulsions.—*Brit. Med. Jour.*

### For Whooping Cough.

In whooping cough try the following:

℞
Ammon. bromide,..... 3 ij.
Fl. ext. chestnut leaves (Tilden's) .. 3 j
Tr. belladonna..... 3 ss.
Syr. tolu .. ..... 3 ij.
Syr. sim.....q. s. ad 3 iv.

M. Sig. Teaspoonful every two or three hours.

### Ulcerative Endocarditis.

At a meeting of the Biological Society, M. Etienne reported a case of ulcerative endocarditis, which appeared to be due to the bacterium coli. The blood of the heart and of the spleen, collected six hours after death, inclosed the bacillus.—*La Tribune Medicale.*

## SURGERY.

### Suppurating Buboes.

Dr. A. Cavazzani, of Venice, recommends the following powder as a dressing after the incision of suppurating buboes:

℞
Iodoform..... 3 ivss.
Salicylic Acid,
Subnit. Bism.....āā 3 ij.
Pulv. Camph..... 3 ss.

M.

The advantages he claims for it are: 1st. It prevents shrinking of the edges of the wound, so frequent with iodoform, and which so greatly retards cicatrization. 2nd. It rapidly deterges the wound and almost completely suppresses suppuration. 3d. Under its influence the inflammed and tumefied glands rapidly diminish in size, and granulations spring up in abundance, in consequence of which cicatrization is greatly hastened. In many cases where suppuration has been slow and the glands have been inflammed a long time, it is well to curette after the pus is evacuated, but this is not often necessary.

Pontan treats suppurating buboes by puncturing the tumor, allowing the contents to escape, then injecting a ten per cent. mixture of iodoform and vaseline. He claims cure in six to eight days.

### Cystitis.

Dr. Dana praises the action of 5-drop doses of thuja occidentalis every three hours.—*Food.*

Gelsemium is said to be beneficial in irritable bladder, especially in hysterical cases.—*Food.*

### Operative Treatment of Knee-Joint Disease.

Dr. DeForest Willard (*University Medical Magazine*) says:

Mechanical treatment by rest, fixation, and the use of crutches, either axillary, perineal, or ischiatic, is absolutely essential both before and after operation.

In children under twelve years of age, conservative measures should be carried to the extreme, and all operative procedures should tend to non-interference with the epiphyseal line for as long a period as possible, in order to assist growth of the limb. In these young cases, therefore, tenotomy with subsequent fixation should be the primary procedure, to be followed by erasion when necessary, and by excision only when life is threatened.

From twelve to fifteen years of age conservatism should still be the rule, although the dangers from a shortened limb subsequent to operation are not so serious after growth has been completed. In adults operative treatment should be early and more radical in character, erasion still being preferable to excision, except in very degenerated cases.

Amputation should be employed in children only as a *dernier ressort;* in adults with extensive disease it is often a wise procedure.

The introduction of anti-bacillary substances, both extra and intra-articular, offers hope of retardation in the growth of bacilli, but as yet the procedure is in the experimental stage.

After the subsidence of all inflammatory symptoms the late deformity should be overcome.

(*a*) By tenotomy, with forcible replacement.
(*b*) By excision; rarely by osteotomy.

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### Chloroforming in Sleep.

It is becoming fashionable for burglars to chloroform their victims in the hope that their work will be the more easily and effectually done. As the plan is to administer the anæsthetic while the patient sleeps, it is no wonder that failure attends the effort. Happily it is one of the most difficult feats to accomplish, requiring the greatest care and the highest degree of skill. By many good observers it has been claimed to be impossible. The latter may be looked upon as the rule, especially with novices. Before primary insensibility is obtained the victim awakes from the irritation of the inhaled vapor, when force is necessary for the completion of the purpose. In the meantime the alarm may be given and the assailant may be captured. Fortunately the chances are always against the latter, as his victim, facing the horror of strangulation, is instantly and almost instinctively roused to desperate resistance. Taking all the chances, however, chloroform in the hands of a burglar should be considered as dangerous to its victim as a club, an axe, or a bullet, and its administration should be punished to that extreme limit of penalty which is due to the employment of the other murderous measures.—*Medical Record.*

## PATHOLOGY.

### Gonorrhœa in Women.

Carry (*Lyon Medical*), has made extensive researches amongst prostitutes and fallen women of other classes, suffering from a vaginal discharge. In only one-third of the number was the gonococcus of Neisser detecthd. Carry insists that the gonococcus is absolutely specific of gonorrhœa. It is very easy to recognize, being quite different in form from any other microbe. In four out of five cases its seat was found to be the urethra, in one in five the cervix. The periurethral follicles, the vulvo-vaginal (Cowper's) glands, the vagina, and anus are exceptional seats of the gonococcus. Gonorrhœal urethritis in women is the almost exclusive source of gonorrhœa in man, and the absence of discharge, pain, and local tenderness all tend to hide the source of contagion.

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## ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM MAY 13, 1894, to MAY 19, 1894.

Leave of absence for four months, on surgeon's certificate of disability is granted Major Van Buren Hubbard, Surgeon.

Leave of absence for three months, on account of disability, with permission to leave the Department of Texas, is granted Captain Alonzo R. Chapin, Assistant Surgeon.

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## NEWS AND MISCELLANY.

### State Board of Medical Examiners of New Jersey.

OFFICE OF THE SECRETARY, No. 319 YORK STREET.
JERSEY CITY, May 21, 1894.

A special meeting of this Board for the examination of candidates desiring to practice medicine in this State will be held in the Capitol, at Trenton, on the third Tuesday of June, (the 19th), *and it will be the last meeting for the examination of candidates held under our present medical law,* as the new law, enacted at the recent session of our legislature, goes into effect July 4, 1894. This new law requires all candidates to have a competent common school education, to be graduates in medicine and surgery which they shall have studied at least four years, and upon which they shall have taken three full courses of lectures, before they can be admitted to the examination for a license, and then all will be subjected to the same examination; it also empowers the Board to accept, in lieu of an examination, the certificates of other State Examining and Licensing Boards, having similar requirements.

Respectfully,
WM. PERRY WATSON, M. D.,
*Secretary.*

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## ORIGINAL ARTICLES.

### THE TREATMENT OF DIPHTHERIA.

FRANK E. COUDERT, M. D., Ph. D., Wallingford, Conn.

The proper treatment of diphtheria occurring in childhood and adult life, is a subject of extreme importance to the general practitioner and specialist.

It is not my purpose to enter into the etiology and pathology of this disease; its treatment alone will concern us.

What can I say to impress upon your mind the importance of *prophylaxis;* if not for you rown sake, for that of your family.

Cailte has urged the importance of a careful inspection of the tonsils and mouth in children, special attention being paid to the care of the teeth and to the tonsils, which, if swollen and irregular, should be removed.

In persons liable to exposure, Loefler recommends the use of antiseptic mouth washes, such as Corrosive sublimate (1-10,000), Chlorine water (1-1,100), or Thymol.

Persons sick with diphtheria should be carefully isolated; no one but the immediate attendants should be allowed to come in contact with the patients. Table utensils, bedding, and clothing used by the sick should be thoroughly disinfected by steam or boiling water before being used by others. Intimate contact with the sick, such as kissing, should be strictly prohibited. There seems no room to doubt that the virus of the disease can also be carried in the clothing. Hence, physicians and nurses should be especially careful in personally disinfecting themselves after contact with a case of diphtheria. After death or recovery of the patient, the apartment occupied during the illness should be disinfected with chlorine or sulphurous acid.

Children recovering from this disease should not be permitted to attend school for at least four weeks after recovery.

Proper disinfection in this disease is of the greatest importance and should be carried out faithfully and systematically from the start to the finish. Lime is a disinfectant *par excellence* in this disease. Its strong disinfectant properties are dependent on the following facts, to wit:—

1. As a caustic alkali it destroys all forms of microscopic life brought in contact with it.

2. As a quick lime it has the property of absorbing moisture to an extraordinary degree.

3. During the process of hydration intense heat is generated, which sets up currents in the surrounding atmosphere, and what germs are floating in the air are brought in contact with it and thus destroyed.

Dr. J. Lewis Smith recommends the following as a disinfectant in the disease:

℞ Ol. Cinnamom.....30 pts.
Ol. Eucalyptus.....180 pts.
Ac. Carbol.....220 pts.
Ol. Terebin.....420 pts.

M. Sig. One ounce (℥i) of this mixture in a quart of boiling water, allow it to simmer on a small stove—alcohol being prepared.

Another disinfectant which I think deserving of mention is Bromine. This substance is extremely destructive to all forms of microscopic life. In all cases where there is gangrenous development, Bromine should be used at once. It is not

a specific against the disease, but it is a disinfectant to be used against its local manifestations, and to prevent the infection from spreading. If the patient is old enough to understand what the operation of swabbing is intended for, and will not struggle against it, it is then permissible. Very young children, I think, are better without it, as it is almost impossible to accomplish anything without a severe fight, and as every muscular exertion gives the heart more work to do, heart-failure is very likely to be the result.

When used, Bromine is best administered in the form of Smith's solution. It is made in the following manner:

Take ʒii of sat. sol. Potass. brom.

To this add slowly with constant shaking one ounce of pure bromine, then add very slowly one ounce of pure water. Four drops of this solution contains one drop of pure bromine. There need be no hesitation in applying this solution clear, as it is not caustic. In the proportion of one drop to the ounce of water, it may be used as a gargle.

The general treatment of diphtheria has made very few advances. The pathologist has proven and shown to us the specific germ. What can we say for the therapeutist? He has taught us a little, but not much. He has demonstrated to us that all our efforts to find a specific, so far have been in vain. For want of something better, the old and much overdone Tincture chloride iron and Chlorate potassium is still in use.

Personally I have little or no faith in their virtues. Dr. H. A. Hare, of Philadelphia, says "chlorate potassium should never be used in diphtheria as the kidneys are already inflamed, and this drug is not only useless when so given, but in addition is a renal irritant."

There are a number of physicans who advocate the forcible removal of the exudate. In my opinion the mechanical removal of the membrane is not permissible, unless already partly detached. It is not a difficult matter to pull off a false membrane by mechanical means, but the second membrane has a deeper intimacy with the tissues then the primary. Furthermore any irritation produced by instruments favors the extension of the diphtheritic process.

To cauterize a diphtheritic membrane I consider wrong, for each one of the escharotic sloughs leaves an ulcer, which is a favorite spot for the development of a new membrane in the tissues.

The thing to be accomplished by local treatment is a suppurative process; this is best done by the inhalation of steam or medicated vapor, and the application of hot fomentations to the neck.

The inhalations should be commenced as soon as the membranous exudation is detected, and continued until it has entirely disappeared. The best method of administering the vapor is by the steam atomizer, as found ordinarily in the shops. My experience has been good with hydrogen peroxid. When hydrogen peroxid is brought in contact with mucous membrane or ulcerated surfaces, albuminous coagulation is immediate, with the formation of a white coating and a rapid evolution of gas. It is a very powerful antiseptic, which has been found to be very poisonous to pathogmic germs. The strength may be gauged to suit the case; very often I use the pure peroxid, 15 volumes. By this method of external treatment we accomplish some important factors in the treatment of this disease.

1. We induce mucous secretion, which produces softening of the false membrane.
2. We make the patient more comfortable.
3. The patient receives the medication in this manner without resistance.
4. It can be kept in constant use by any person of ordinary intelligence, and is non-irritating to mucous surfaces of the eye.

The three principal dangers with which we have to contend with in diphtehria are:

1. Heart failure.
2. Systemic infection.
3. Asphyxia from local causes.

Heart failure should be combatted by every known means. All unnecessary handling of a child, sick with this disease, should be prohibited in strong language.

As a cardiac stimulant, alcohol is our sheet anchor, and the amount that a child can take who is suffering with this disease is certainly surprising.

Dr. Jacobi says: "The fear of a bold administration of alcohol will vanish as does that of large doses of opium in peritonitis."

Food in an indirect way is a powerful cardiac stimulant. Hence, proper

nourishment is of great importance. Milk diluted with lime water, beef tea, egg albumen, etc., are all easily taken and most suited to the stomach. Evacuation of the bowels should be had at proper intervals, and if Nature does not accomplish what is demanded of her, artificial means must be resorted to.

Next to alcohol, I depend upon caffeine in doses ranging from one-half to five grains every three-fourths hour. It is a most valuable remedy as a cerebral and cardiac stimulant, and as a diuretic. As a cardiac stimulant it is superior to digitalis in never disagreeing with the stomach, in having no distinctive cumulative tendency, and in the promptness of its action.

The ordinary salts of caffeine are, however, not available for hypodermic use, because they are decomposed in the presence of water. The double benzoate of sodium and caffeine has been proposed as moderately stable and free from irritant properties. The following formula has been commended by M. Fauret for hypodermic use:

℞ Sodium Salicyl.....gr. xxxi.
Caffeine.....3ii.
Aquæ Distillat.....gr. 60.

Systemic infection is best met by the judicious use of Bichlorid of mercury. This is best done by giving 1-32 gr. every hour or two.

Dr. Jno. S. Coleman, of Augusta, Ga., reported a case of a child four years of age, taking seven and one-half grains of this powerful drug in thirty-six hours, at the end of that time she coughed up a whole piece of membrane, which was a perfect cast of the trachea. After this the child went into convalescence, which was rapid and complete.

Bartholow says: "Corrosive sublimate has lately been used with very distinct success in the treatment of diphtheria. Its remarkable germicide property is the motive for its employment, and clinical experience strongly supports the result of experiment."

A few words about the temperature and I have finished. When the fever is high and the skin hot, sponging with tepid or cold water, diluted with alcohol, will be grateful to the patient. If the feet are cold the bath is contra-indicated, and we must resort to internal antipyretics with an increased amount of stimulation, and place hot water bottles at the feet.

If at any time the temperature should become subnormal, a hot bath or pack must be given. Sometimes a hot rectal injection will be of benefit. Great care should be taken when giving very young children cold applications, for as a rule they bear them badly.

Out of the large number of antipyretics at our command, there are only a few which we can use with safety in this disease. Of late I have relied upon quinine and acetanilide combined with caffeine.

By combining caffeine with either of these drugs, we accomplish three things:

1. It improves the appetite and is feebly laxative, owing probably to its action in stimulating the glands of the mucous membrane.

2. Its stimulating action upon the heart and circulation acting more rapidly than digitalis, causing free diuresis in twenty-four hours; it slows the pulse and raises the arterial tension, thus giving a better distribution of blood.

3. Being somewhat anodyne it has a quieting influence upon the nervous system.

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Authors referred to: Bartholow's Nat. Med., Loomis's Practice, Brunton's Nat. Med., Pepper's System of Med., Stümpell's Practice Med., Osler's Practice Med., U. S. Dispensatory for 1894.

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### Itching Piles.

℞ Vaselin..... 3j.
Ichthyol..... 3j.
M. Sig.: Apply often.

Or,

℞ Cosmolin..... 3j.
Menthol..... 3ss.
Chloral Hydrate..... gr. xx.
M. Sig.: For local use.

—*Mathew's Med. Quarterly.*

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### Asthma.

In the intervals of attack, if the patient is gouty, give for twenty days out of each month:—

℞ Iodide of Strontium..... 3iiss.
Tincture of Lobelia..... 3ss.
Tincture of Opium..... 3v.
Linden Water..... 3iij.
M. Dose: Tablespoonful in the morning.

—*La Tribune Med.*

# METALLIC TRACTORS AND PERKINISM: A LOST ART IN MEDICINE.

CHARLES B. WILLIAMS, A. B., M. D.,* PHILADELPHIA.

Metallic tractors were small bars of metal which were supposed to have certain magnetic properties and the power of curing various painful affections, and of causing tumors to disappear by being drawn over the part.

The inventor of the metallic tractors was Elisha Perkins, who was born at Norwich, Connecticut, in January, 1740. He received a liberal education from his father, Dr. Joseph Perkins, and finally took up the profession of medicine.

We are told that "he was indebted to nature for uncommon endowments, both bodily and mental. He possessed extraordinary ability to endure fatigue. In person he was six feet high, and of remarkable symmetry. His reputation and success as a physician were considerable, but he is principally known by his metallic tractors."

After long study and numerous experiments, Dr. Perkins, by the aid of various metals, formed two instruments about three inches in length and pointed at one end. The one having an appearance of steel, the other of brass. The mode of application was to draw the points over the affected parts in a downward direction for about fifteen or twenty minutes at each seance.

Dr. Perkins claimed that some remarkable and potent influence was thus brought to bear upon the nerves and muscles. Localized inflammations in the head, face, teeth, breast, stomach; rheumatism, tumors, etc., were all markedly benefited by an application of these little rods, and in some cases the trouble disappeared as if by magic, with no subsequent return of the malady.

Dr. Perkins patented his invention. The success that he obtained was noised even across the Atlantic. It is stated that the professors of three universities in America strongly endorsed Dr. Perkins' views and gave attestations in favor of the remarkable cures that he brought about. "In Copenhagen twelve physicians and surgeons, chiefly professors and lecturers in the Royal Frederick Hospital, commenced a course of experiments, accounts of which were put in an octavo volume." It was in Copenhagen that the term Perkinism arose; the Faculty having so designated this special form of treatment in honor of its discoverer.

In London, a *Perkinian Institution* was established chiefly to benefit the poor by the use of the tractors. But after the institution had been established but for a short time, communications and visits were received from professional men from all parts of Great Britain. It is claimed that professors, physicians, surgeons, and clergymen swarmed like bees in a hive around this new retreat of Æsculapius. Red noses must have been common in those days in England, for it has been estimated that one million five hundred thousand cures were effected.

Dr. Perkins came to New York in 1799, during an epidemic of yellow fever, for the purpose of trying the merits of a highly antiseptic remedy which he had introduced to the notice of the profession, but after remaining four weeks in New York he contracted the disease himself and died, æt. 59.

The writer has in his possession a rare and amusing caricature of Gilray's, that was executed at the time when Perkinism was the rage in London. It represents a follower of Perkins' charming away a *hyperæmia nasi* with his magical "rods of Æsculapius," the metallic tractors. The poor martyr to *podagra*, with a nose that defied even a true "pigeon's-blood" stone for its rubicundity, is seated in his arm-chair, groaning and wincing under the severe operation of having his red nose charmed away by an application of the metallic tractors. In formidable array upon a table at his side a decanter of brandy and a pitcher of hot water are placed together, with a bowl of lump-sugar and a sliced lemon, and all of the necessary paraphernalia for making a "hot toddy" or a bumper of "Hippocras," in which our great-great-grandfathers of the "good old times" were often too prone to

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indulge. Upon his lap lay a smoking, long-stemmed pipe, and a crumpled copy of *The True Briton.* It will be interesting to read the first page of this old English daily. It is as follows: "Theatre, Dead-Alive! Grand exhibition in Leicester Square—Just arrived from America, the 'Rod of Aesculapius.' Perkinism in all its glory, being a certain cure for all disorders: Red Noses, Gouty Toes, Windy Bowels, Broken Legs, Hump Backs; just discovered the grand secret of the Philosopher's Stone, with the true way of turning all metals into gold, *pro bono publico*, etc., etc."

From a merely cursory glance at Gilray's caricature it will easily be seen that this great artist was not, like many people of his time, a firm believer in Elisha Perkins and his magical wands.

So it is with many new discoveries in medicine, like the wonderful panacea "tar water" of Bishop Berkeley, and the *elixir vitae* of the late venerable Brown-Sequard, they will all have their day. Nay, they may even turn the universe upside down for a while, but their fall is assured, and when they do fall, it is always into the blackest oblivion.

## UTERINE FIBROIDS.

CHARLES P. NOBLE, M.D.,* PHILADELPHIA.

In no subject in gynæcology has there been a greater revolution in its principles and practice within recent years, than in that of uterine fibroids. Ten years ago it was universally taught that fibroid tumors or myo-fibromatous degeneration of the uterus, is an essentially benign disease, which seldom if ever causes death, and which in the course of time undergoes a spontaneous cure during or after the menopause. The treatment which was based upon this theory of the nature and course of the disease was a purely palliative one, and consisted in combating symptoms as they arose, by drugs, by hygienic measures, or by minor surgical procedures. When the physician made a diagnosis of uterine fibroids, he congratulated himself and also his patient upon the fact, that as she had a tumor, it was a fibroid tumor of the uterus rather than an ovarian tumor, and that, as a consequence, she would not be obliged to undergo an abdominal section for its removal. It is true that hysterectomy was done at times in those cases in which, in spite of the usual measures employed, the life of the patient was put in serious jeopardy, either by uterine hemorrhages, or by obstruction caused by pressure of the tumor either upon the urinary organs or upon the alimentary canal.

Also, in a certain number of cases, in which hemorrhage was a marked feature, the ovaries were removed in order to bring about the artificial menopause. Hysterectomy was regarded as perhaps the most dangerous operation in surgery, and its inherent mortality was believed to be 30 or 40 per cent.

The foregoing is a fair representation of principles and practice with reference to uterine fibroids which prevailed until within a very recent time. To make the representation complete, it should, of course, be added that when the fibroids became polypoid, they were at times removed *per vaginam.* It is unnecessary to state that the present status of the subject is very widely different from that which has been detailed. This change has been brought about partly by more extended and accurate observation concerning the natural history and tendency of the disease, and partly by the general improvements which have been made in surgery, and more especially in abdominal surgery. The improved results of modern operative procedures could not help but influence the minds of gynæcologists, concerning the possibilities of the operative treatment of uterine fibroids. The old and received opinion that uterine fibroids never cause death was first shown to be misleading. It was demonstrated, and this is, I believe, no longer disputed, that uterine fibroids occasionally cause death directly from hemorrhage; more often indirectly by breaking down the general health and by paving the way for intercurrent disease, either an acute disease, or the chronic diseases which

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attack the feeble, the anemic and the badly nourished. It was also shown that fibroids occasionally undergo degenerative changes, either of a malignant character, more especially sarcomatous degeneration; that they undergo cystic degeneration, in which case the rapid growth and pressure of the tumor brings about death, just as does an ovarian tumor; and, on the other hand, that they undergo inflammatory and necrotic changes, and cause death by inducing septicemia; and, finally, that at times they produce death in accidental ways, as for example, by pressure upon the ureters or upon the bowels; or by offering an obstruction to labor, or by producing *post partum* hemorrhage. The old observations that the menopause in women having fibroid tumors is delayed for from five to ten years has been emphasized, hence a woman who has a fibroid tumor at thirty or thirty-five years of age, has a prospect of menstrual life of from twenty to twenty-five years. It has been further proven that the old teaching that fibroid tumors undergo a spontaneous cure after the menopause is erroneous if taken in an absolute sense, because in a large number of cases, instead of undergoing atrophy and absorption after the menopause, the tumors take on a new growth and develop much more rapidly after the cessation of menstruation than they have done during menstrual life. This is especially true of soft myometa, which are not at all influenced by the menopause. It has also been shown that degenerative changes, either malignant, cystic, or necrotic, are as liable to occur after the menopause as before it.

These facts, which have been briefly summarized, appear to be well substantiated. My own experience so far as it goes, is entirely in accord with the views just expressed. The position of the practitioner at this time must, therefore, be very different with reference to the management of fibroid tumors from that of his predecessor of ten years ago. He must regard the disease as a very serious one, which will as a general rule make a chronic invalid of his unhappy victim, even though it may not cause death in one of the various ways already mentioned. He can no longer hold out to her as an inducement to suffer until the menopause the ills which the disease entails upon her, the assurance that after that event she will become spontaneously well and be relieved of her disease without submitting herself to the risks of an operation, as it has been shown that this is not true in many cases. This inducement was the very basis of the old advice, and was the hope which stimulated and encouraged the many sufferers from fibroid tumors to undergo the years of suffering and invalidism which the disease entailed upon them.

On the other hand, instead of being obliged to say that the removal of the fibroid tumor by hysterectomy is one of the most dangerous operations in surgery, having a mortality of from thirty to forty per cent., he can now say that the operation is no more dangerous than the average of abdominal operations, and that, indeed, it is almost as free from risk as the removal of a simple ovarian tumor. The results of the last few years simply bear out the statement that hysterectomy for healthy fibroid tumors which are free from adhesions, done upon women in reasonably good condition is one of the safest of major operations. The risks of the operation depend upon its complications. Diseased appendages, intestinal adhesions, burrowing of the tumor into the broad ligaments, with displacement of the ureters, necrotic changes in the tumor, malignant degeneration, and suppuration, are the local conditions which are liable to bring about death after operations for uterine fibroids. These conditions, however, are only exceptionally met with, and are found especially in old and neglected cases. The increased dangers of the operation in such complicated cases has, however, only a relative bearing upon the dangers of the removal of healthy fibroids from a healthy peritoneal cavity, and serves as an argument for the early removal of fibroids before such complications and dangers shall have arisen.*

The development of the modern operations for the removal of uterine fibroids

*In order to show that the foregoing statements with reference to hysterectomy have an absolute basis in fact, I have written to Drs. Kelly, Baer and Polk, requesting their recent hysterectomy statistics. The replies follow:

Dr. Kelly reports fifty-seven hysterectomies, two deaths. Dr. Baer, fifty-seven hysterectomies, three deaths. Dr. Polk, forty hysterectomies, three deaths. Adding my own, fourteen hysterectomies, one death, we have one hundred and sixty-eight hysterectomies, nine deaths, or 5.3 per cent. mortality. These statistics mostly extend over the last four years.

(other than polypi) has been along two lines. Koeberlé, Keith, Bantock, Hegar and Price, have been instrumental in originating or perfecting the so-called extra-peritoneal method of treating the stump, using either a wire constrictor—*the serre-noud*—or a rubber ligature, to control hemorrhage from the stump. The work of these men has been of the greatest importance, because of the impetus which it gave to the surgery of fibroid tumors. Within recent years, with the improvements which have been made in the method, it has become applicable in the removal of a very large percentage of fibroid tumors, and the results obtained with it in some hands have been most excellent, the mortality being as low as five per cent. The method has serious disadvantages, however, in that it is not specially applicable to sessile tumors, or to tumors of moderate size which have not escaped from the pelvis, and that in addition to this, it leaves a stump to come away by gangrene, either dry or moist, and requires the subsequent closing of a granulating wound; which fact renders the convalescence from the operation a tedious one, lasting from six to eight weeks, and also leaves a weak spot in the abdominal cicatrix which very frequently results in the subsequent development of a ventral hernia.

The serious disadvantages of this method of treatment led other surgeons to adopt the method of treating the stump within the abdomen. Schroeder amputated the tumor very much as the leg is amputated by the flap method. These flaps were then brought together by a series of sutures, some of which were buried, the effort being made to control hemorrhage by ligatures placed in the tissue of the uterus or cervix itself. In consequence of the contractile nature of the uterine tissue many of these patients bled to death. In other cases, the multiplicity of the ligatures employed produced sloughing of the stump, and death resulted from sepsis. Death from this cause also resulted from the imperfect antiseptic technique employed at that time. As a result Schroeder's mortality was about 30 per cent.

Various operators desiring to avoid the disadvantages of attaching the stump in the abdominal wound, and recognizing the high mortality of the method employed by Schroeder, have made modifications in his method, with the result, that at the present time, the method of treating the stump within the abdomen gives as good, if not better, results than the so-called extra-peritoneal method. Prominent among these operators must be mentioned Kelly, Goffe, Dudley, Chrobak, and last, but by no means least, my fellow-townsman, Dr. Baer. Dr. Baer, more than any one else, has been instrumental in popularizing the method of treating the stump *within the abdomen*, but *external to the peritoneum*, and in showing that the safety of this method depends upon securing the vessels within the broad ligaments, rather than by placing ligatures in the uterine tissue, as was done by Schroeder and all those who came after him. This point of securing the vessels within the broad ligament was first emphasized by Dr. Stimson. He accomplished it by searching for the vessels and ligating them in their course, just as arteries are ligated in other portions of the body. The merit of the operation as done by Dr. Baer, is that he substituted the mass ligature, with which abdominal surgeons are all familiar, so that all the vessels can be secured in a simple and speedy manner.

Progress along the lines laid down by Schroeder has resulted then in the evolution of an operation radically different from his, and which is exactly described as a supra-vaginal amputation of the myomatous uterus, with the intra-abdominal but extra-peritoneal treatment of the stump. The essential improvements over Schroeder's operation are:

1. The vessels are secured by ligating both broad ligaments from the infundibulopelvic ligament to the vagina, instead of by ligatures placed principally in uterine tissue.

2. The uterus is amputated at or about the level of the vagina, leaving but a small cervical stump to be nourished, instead of a considerable portion of the uterus, as in Schroeder's operation, thus lessening the probability of sloughing.

3. Peritoneal flaps which have been stripped off from the tumor in front and behind, are sewed over the field of operation, thus making the wound practically extra-peritoneal, instead of bringing the flaps of uterine tissue together and matching the peritoneal edges, as in Schroeder's operation. After from twelve to twenty-four hours, hemorrhage from or inflamma-

tion of the stump is, extra-peritoneal in the new operation, instead of intra-peritoneal as in Schroeder's operation.

Other surgeons recognizing the inherent risks of the method of Schroeder, and seeking to overcome them, have revived Freund's operation, or total extirpation of the uterus. Polk and Krug of this country, and Martin of Germany, have been leaders in this line of development. They secure the vessels in the broad ligament, in the same manner as in the operation just described, but instead of amputating the uterus at the level of the vagina, they cut through the vagina and remove the uterus entire. In both operations the field of operation is covered over by suturing together flaps of peritoneum, so that an intact peritoneum is left on the pelvic floor after the lapse of twenty-four hours.

The three operations just described are those which are now in general use for the removal of fibroid tumors, and generally speaking, operators prefer to employ one or other of them in the treatment of this disease. In my judgment, however, it is true that they are not applicable to all cases, therefore brief reference will be made to other methods of treatment.

THE REMOVAL OF THE OVARIES.—The removal of the ovaries for the cure or relief of fibroid tumors is not done so frequently now as it was some years ago. The reason is that it sometimes fails to afford relief in all varieties of fibroid tumors; that it has little or no influence upon the development of the soft myomatous tumors; that in some cases it is as difficult and as dangerous as hysterectomy itself; while in other cases, it is not feasible because of the location of the ovaries under the tumor, or because the ovarian tissue has become drawn out by traction over a wide surface, so that the removal of the ovaries becomes impracticable. Although I believe all that has been said concerning the disadvantages of this operation, I still think that it has a small field of usefulness, and practice it occasionally even at the present time. In my hands it has always yielded good results. I consider that its chief field of usefulness is in the treatment of small hard fibroids, which have given rise to such hemorrhages that the patient is so markedly reduced in vitality, that it is not desirable to subject her to an operation requiring more than a few minutes for its performance. In such cases, by bringing about the menopause, the patient is either cured symptomatically or, at all events, is given an opportunity to recover strength, and undergo a subsequent hysterectomy if this proves necessary. Within the past year I have removed the ovaries under these conditions, and some two weeks later curetted the uterus and did a high amputation of the cervix, taking care to put a ligature around each uterine artery. This patient has done well.

LIGATION OF THE UTERINE ARTERIES.—It has been proposed by Martin, of Chicago, and by Gottschalk, of Germany, to ligate both uterine arteries as a systematic method of treatment for fibroid of the uterus. The operation has been advocated especially for the class of cases for which the removal of the ovaries is indicated, because their condition hardly justifies the performance of hysterectomy. This procedure is yet in its infancy, but it promises well as a temporary expedient at least, even though the expectation of its proposers, that it will bring about atrophy of the tumors, is not realized. I was quite prepared to accept this operation by the results I have seen from ligating the uterine arteries in amputating the cervix for procidentia, the uterus rapidly undergoing involution after the operation. I have done the operation twice with satisfactory results.

ERGOT AND ELECTRICITY.—The treatment of fibroid tumors by the use of ergot and by electricity has been tried by the profession and found wanting. Both these agents have a narrow field of usefulness in the management of certain cases, but as a systematic means of treatment, it can be stated that they are not to be depended upon. Certain fibroid tumors have been cured by the use of ergot, more especially the cases of sub-mucous fibroids, by bringing on a miniature labor, and thus expelling them from the cavity of the uterus. The dangers from hemorrhage and sepsis in such cases, however, are far greater than are the risks of hysterectomy. A small number of cases have been reported cured under the influence of electricity, but an analysis of such reports shows that in almost every case the patients had reached or passed the menopause. When, in addition to this, it is remembered that fibroids have been known to markedly diminish in size, or to disappear, after

labor, and after the mere opening of the abdominal cavity, it is not surprising that the same event should, in rare instances, occur after the employment of so powerful an agent as electricity. Not only has electricity proved a failure in causing the disappearance of fibroid tumors, but also unfortunately it has been shown by experience to produce death from sepsis and peritonitis, in a not inconsiderable percentage of cases.

My personal experience in the operative treatment of fibroid tumors has embraced thirty cases. Of these, three were the removal of sloughing fibroid polypi *per vaginam;* thirteen were abdominal sections for the removal of the uterine appendages; and fourteen were abdominal sections for the removal of the tumors themselves by hysterectomy. In the thirty cases there was one death, being the last operation of the series. This operation was a very difficult hysterectomy, in a woman having in addition to the fibroid tumor, double hydro-salpinx. She had been an invalid for many years, had suffered many attacks of peritonitis, and was admitted to the hospital much debilitated from long continued hemorrhages and pain. Death was due to a combination of shock and sepsis, which resulted from the rupture of one of the diseased tubes and the escape of bloody septic fluid therefrom.

Appended are tables of the abdominal operations for fibroid tumors.

The comparatively small number of operations which I have done for fibroid tumors, is evidence of the fact that for a long time I was profoundly influenced in my practice by the old teaching concerning this disease. It was not until my own observations convinced me of the fallacies of past teaching, that I felt justified in resorting to the removal of fibroid tumors, except in the worst class of cases. I am coming more and more to believe, however, that it is the part of wisdom to remove fibroid tumors which are producing symptoms, as soon as they are discovered. In other words, that the principle of early operation, which is now generally accepted with reference to ovarian tumors, is equally applicable in the treatment of fibroid tumors. In this way, women are spared the dangers of possible pregnancy, years of invalidism, and the risk of death from the continued development of the tumor. It will be observed that this general statement does not include the tiny little sub-peritoneal fibroids which are quiescent, and therefore produce no symptoms.

Conclusions.—(1). Fibroid tumor, or myo-fibromatous degeneration of the uterus, is a serious disease, which entails years of invalidism upon its possessor, and which causes death in a not inconsiderable percentage of cases.

(2). Palliative treatment yields uncertain and unsatisfactory results.

(3). Hysterectomy done by either of the three modern methods is a comparatively safe operation, and should be followed by a mortality not exceeding five per cent., in good hands.

(4). The principle of early operation is as applicable in the treatment of fibroid tumors of the uterus, as in that of ovarian tumors. Its acceptance will decidedly lessen even the present mortality of the operation.

[See tables on following pages.]

Case 8.—One large tumor enucleated from under peritoneum. The large oozing surface was packed with gauze, and an opening made in the vagina for its removal. The peritoneum was sutured above the gauze, so that it was extra-peritoneal.

Tumor almost entirely sub-peritoneal. Posterior half of pelvis denuded of peritoneum. Cavity packed with gauze; opening made in vagina; bladder sewed to posterior margin of peritoneum, leaving gauze extra-peritoneal and obliterating the pelvic cavity.

### Table III.

#### Cases of Removal of Fibroid Polypi per Vaginam.

Case 1.—Seen with Dr. Saltmarshe. Single: anæmic from repeated hemorrhages; septic; almost *in articulo mortis*. Sloughing fibroid four inches in diameter removed per vaginam. Recovery; subsequent marriage; maternity.

Case 2.—Seen with Dr. Hess. Married; condition much the same as Case 1; less anæmic but more septic. Sloughing fibroid two and a half inches in diameter removed per vaginam. Long continued sepsis; recovery; subsequent good health.

Case 3.—Seen with Dr. Avison. Married; multipara; condition fair; anæmic. Fibroid polyp removed per vaginam; both uterine arteries tied; recovery.

Exact data concerning these cases not available.

## Table of Cases of Cœlotomies for Fibroid Tumor of the Uterus—Not Including Hysterectomies.

| No. Name. Date. | AGE. | M.S.W. | PAR. | MISC. | DISEASE. | CONDITION | OPERATION. | TIME. | DRAIN. | COURSE. | TEMP. | UNION. | Hospital or Private | RESULT. | Discharge. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1, 28, '90 Mrs. A. (1) | 35 | M. | 4 | 2 | Uterine fibroma. | Worn. | Cœlotomy: left uterine appendage removed. Right not removed owing to a torsion of the uterus. | 40 min. | 48 hours. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 2, 2, '90 |
| 4, 15, '90 Mrs. B. (2) | 44 | M. | 2 | 2 | Uterine fibroid and double hydrosalpinx. | Fair. | Cœlotomy: removal of both uterine appendages. | 40 min. | 50 hours. | Phlebitis 3d wk mild | Slight fever 3d w'k. | Primary. | Hospital. | Recov. | 5,13,'90 |
| 10, 15, '90 Miss W. (3) | 30 | S. | 0 | 0 | Uterine fibroid. | Anæmic. | Cœlotomy: removal of both uterine appendages. | 20 min. | 48 hours. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 12,20,'90 |
| 3, 23, '91 Miss L. (4) | 17 | S. | 0 | 0 | Utertne fibroid. | Good. | Cœlotomy: exploratory operation abandoned. Bladder anomalous extending to within one inch of the umbilicus. | 30 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 4,27,'91 |
| 9, 5, '91 Miss M. (5) | 33 | S. | 0 | 0 | Uterine fibroid with cyst of left ovary. | Good. | Cœlotomy: removal of both uterine appendages. | 30 min. | 48 hours. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 10,3,'91 |
| 11, 5, '91 Miss M. (6) | 30 | S. | 0 | 0 | Uterine fibroid with cyst of left ovary. | Fair. | Cœlotomy: removal of both uterine appendages. | 35 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 12,5,'91 |
| 12, 3, '91 Mrs. Mc M (7) | | M. | 0 | 0 | Uterine fibroid. | Fair. | Cœlotomy: removal of both uterine appendages. | 25 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 1, 1, '92 |
| 2, 17, '92 Mrs. S. (8) | 40 | M. | 0 | 0 | Uterine fibroid. | Anæmic. | Cœlotomy: exploratory operation abandoned because of collapse of patient. | 30 min. | None. | Ether Pneumonia. | Febrile. | Primary. | Hospital. | Recov. | 4, 1, '92 |
| 2, 23, '92 Mrs. A. (9) | 30 | M. | 0 | 0 | Double hydrosalpinx. Left intraligamentous suppurating cyst fibroid of uterus. | Fair. | Cœlotomy: removal of both uterine appendages. | 2½ hours. | 3 days. | Uninterrupted. | Febrile slight. | Primary. | Hospital. | Recov. | 5, 3, '92 |
| 10, 27, '92 Mrs. B. (10) | 33 | M. | 1 | 0 | Small uterine fibroid. Right ovarian cyst; left ovaritis. | Fair. | Cœlotomy: removal of both uterine appendages. | 35 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 11,27,'92 |
| 8, 8, '93 | 40 | M. | | 1 | Uterine fibroids. Rt. ovarian tumor solid and cystic; double salpingitis, | Bad. | Cœlotomy: removal of both uterine appendages. | 35 min. | 48 hours. | Uninterrupted. | Slight fever. | Primary. | Hospital. | Recov. | 9, 3, '93 |
| 8, 27, '93 | 39 | M. | | | Uterine fibroids. | Fair. | Cœlotomy: removal of both uterine appendages. | 30 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 9,29,'93 |
| 1, 29, '94 Mrs. Y. (13) | 35 | M. | | | Uterine fibro-sarcoma. | Bad. | Cœlotomy: removal of both uterine appendages and tumor. | 90 min. | Tube & gauze. | Peritonitis. | Febrile. | Primary. | Hospital. | Recov. | 3,10,'94 |

## Table of Hysterectomies for Fibroid Tumor of the Uterus.

| No. Name, Date. | AGE. | M.S.W. | PAR. | MISC. | DISEASE. | CONDITION | OPERATION. | TIME. | DRAIN. | COURSE. | TEMP. | UNION. | Hospital or Private. | Result. | Discharge. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5, 21, '91 Mrs. B. (1) | 46 | M. | 2 | 0 | Large œdematous myoma of uterus as large as full term pregnancy. | Good. | Cœlotomy: Hysterectomy: Kœberlé serre-nœud. | 2 hrs. | 24 hours. | Stump cut off on the 10th day. | Afebrile. | Primary. | Hospital. | Recov. | 7, 15, '91 |
| 10, 19, '91 Mrs. K. (2) | 36 | W. | 0 | 0 | Fibro cyst of uterus. | Very bad. | Cœlotomy: Hysterectomy: Rubber ligature. | 2 hrs. | Yes. | Stump cut off on 11th day. | Afebrile. | Primary. | Hospital. | Recov. | 11, 2, '91 |
| 7, 9, '92 (3) | 40 | W. | 5 | 0 | Large soft fibroid. | Worn. | Cœlotomy: Hysterectomy: Kœberlé serre-nœud. | 75 min. | None. | Slow convalescence. | Afebrile. | Slough from the Stump. | Hospital. | Recov. | 8, 19, '92 |
| 2, 2, '93 Mrs. G. (4) | 51 | M. | Multi. | Multi. | Fibro-sarcoma. | Poor. | Cœlotomy: Hysterectomy: Pedicle dropped. | 75 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 3, 16, '93 |
| 5, 31, '93 Mrs. D. (5) | 43 | M. | Multi. | Multi. | Uterine fibroma. | Fair. | Cœlotomy: Hysterectomy: Freund's operation. | 1 hr. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 7, 7, '93 |
| 7, 31, '93 Miss B. (6) | 40 | S. | 0 | 0 | Uterine fibroma multinodular. | Fair. | Cœlotomy: Hysterectomy: Cervix left in, pedicle dropped. | 75 min. | None. | Uninterrupted. | Afebrile. | Primary. | Private. | Recov. | 9, 2, '93 |
| 11, 6, '93 Mrs. R. (7) | 46 | M. | 13 | 4 | Uterine fibromyoma. | Bad. | Cœlotomy: Hysterectomy: Pedicle dropped. | 60 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 12,14,'93 |
| 10, 28, '93 Mrs. Y. (8) | 41 | M. | 1 | 0 | Uterine fibromyoma. | Good. | Cœlotomy: Hysterectomy: Pedicle dropped. Pelvis packed with gauze under peritoneum. | 80 min. | 48 hours. Glass and Gauze. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 11,29,'93 |
| 12, 1, '93 Mrs. L. (9) | 34 | M. | 0 | 0 | Uterine fibromyoma. | Anæmic. | Cœlotomy: Hysterectomy. | 60 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 12,27,'93 |
| 1, 11, '94 Mrs. K. (10) | 38 | M. | 0 | 0 | Uterine fibromyoma. | Anæmic. | Cœlotomy: Hysterectomy. | 40 min. | 24 hours. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 2, 8, '94 |
| 2, 19, '94 Miss L. (11) | 42 | S. | 0 | 0 | Uterine fibrocyst | Good. | Cœlotomy: Hysterectomy. | 95 min. | Gauze. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 3, 17, '94 |
| 2, 26, '94 Miss McN. (12) | 30 | S. | 0 | 0 | Uterine fibromyoma. | Good. | Cœlotomy: Hysterectomy. | 40 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | 3, 27, '94 |
| 4, 28, '94 Mrs. R. (13) | 49 | M. | 4 | 0 | Multinodular fibroid. | Fair. | Cœlotomy: Hysterectomy. Pedicle dropped. | 45 min. | None. | Uninterrupted. | Afebrile. | Primary. | Hospital. | Recov. | Still in Hospital. |
| 5, 10, '94 Mrs. G. (14) | 45 | M. | 0 | 0 | Multinodular fibroid: double hydrosalpinx. | Poor. | Cœlotomy: Hysterectomy: Pedicle dropped. | 90 min. | Glass and Gauze. | Uninterrupted. | Febrile. | | Hospital. | Died. | 5, 13, '94 |

# COMMUNICATIONS.

## OPERATION FOR FIBRO-CYSTIC SARCOMA INVOLVING THE RIGHT INFERIOR MAXILLARY BONE.*

J. McFADDEN GASTON,† M. D., ATLANTA, GA.

A colored woman, thirty-five years old, with regular menstruation, and having borne several children, enjoyed general good health until a tumor made its appearance some years ago, for which she underwent an operation for partial removal of the right lower jaw. She presented herself with a reproduction of the growth at the clinic of the Southern Medical College on January 24, 1894, and upon examination I found a large mass involving the region from the angle to the mental curve of the right lower maxillary bone, extending upward to the zygomatic arch and inward to the root of the tongue. There was a protuberance of indurated substance in the middle and a tense elastic portion above, with a larger formation of the same character below. The two last named developments were evidently cysts, while that which lay between them gave the impression upon palpation of the consistence of cartilage. The entire cavity of the mouth on the right side was filled with the tumor. There is a cicatricial line extending from the middle of the lower lip along the margin of the right jaw to near its angle, which indicates the incision made in the previous operation performed about two years ago. The patient states that the growth commenced some years prior to that time. The exact limits of the primary growth, or the details of the extent of the measures adopted by the former operator, could not be accurately ascertained, but it is evident that all the diseased structures were not removed, and hence the redevelopment of the tumor. The indications led to the view that the new growth was a fibro-cystic sarcoma, and that its early removal was the only chance for prolonging the life of the patient. Upon informing her and her husband of the certainty of a fatal result without operation, and of the risk to life from the removal of the tumor, they took the matter under consideration, and subsequently notified me that she would prefer to avail herself of the operation before the medical class.

Accordingly, she was instructed to take two compound cathartic pills night and morning to procure free evacuations from the bowels, and to refrain from food on the morning of the 31st of January, preparatory to undergoing the operation at my regular clinic on that day.

The field of operation having been thoroughly cleansed, a hypodermic of one-fourth grain of morphine and one-one hundred and fiftieth grain of atropine was given, and she took an ounce of rye whiskey with a little water, after which the A. C. E. mixture was inhaled from an ordinary towel cone, until she was fully anæsthetized.

With the assistance of Drs. L. B. Grandy, E. C. Davis and J. McF. Gaston, Jr., I proceeded with the various steps indicated for the complete removal of the tumor with the jaw-bone. At the outset a strong silk ligature was passed through the tongue and its ends knotted together, so as to form a loop, which was to be made available to prevent the tongue from dropping back and interfering with respiration at a subsequent stage of the operation. This precaution is made requisite from the record of cases in which suffocation has resulted from its omission, when the lateral attachments of the tongue have been severed.

The next step was the extraction of two of the lower incisor teeth, where it was expected to divide the thick bony structure subsequently, either with the saw or bone forceps. This would effect its detachment in front and another section behind the angle of the jaw, through the condyloid neck would separate the bone behind, so that all the intervening portion of the lower maxillary bone on the right side should be detached with the tumor. It was supposed that the facial artery had been ligated in the former operation, and hence that its trunk was obliterated, but that the collateral circulation had been established to some extent by the an-

*Read before the Medical Association of Georgia, in Atlanta, April 18, 1894.

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astomosing vessels, so that some small branches would be encountered in proceeding with the dissection. It may be noted, however, that in the removal of malignant tumors, the nutrient vessels have been found usually so small as not to require ligating, and even the regular supply of arteries generally undergo atrophy to a considerable extent in the vicinity of the neoplasm, owing, perhaps, to compression.

My greatest concern in regard to hemorrhage connected with this operation was relieved by the expectation of leaving the condyloid process and thus obviating the risk of wounding the internal maxillary artery by its removal. This vessel lies in such close proximity to the inner face of the bone that the steps for its disarticulation require great caution against wounding it, and it branches off from the external carotid so that ligation is difficult. Having planned to accomplish the incision and dissection, so far as possible, without entering the buccal cavity, and thus avoid the entrance of blood into the fauces, I first divided the skin from a point immediately below the middle of the lower lip along the line of the cicatrix from the former incision back to the angle of the right lower jaw, and thence upward to the prominence of the zygoma, keeping away from the temporal artery in front of the ear. The skin was then dissected back on the lower side from the tumor and in like manner above to the zygomatic arch, thus exposing the exterior surface of the diseased structure without entering the buccal cavity. The few cutaneous arteries which were divided were secured with artery forceps in the course of the dissection on the lower border.

At this stage, the lip which had been left intact in the first incision, was divided and the tissues separated from the bone until the point was reached for its detachment.

Having incised the periosteum over the surface of the lower maxillary, on a line with the socket from which the incisor was extracted, a saw was passed over the outer surface of the bone and then a strong pair of bone forceps was used by Dr. Grandy to divide the bone from above downward. I then used the same forceps to separate the bone just behind the angle and proceeded to dissect up the close attachments of the masseter and temporal muscles from the coronoid process. This left the resected portion of the lower maxillary imbedded in the tumor and all could readily be lifted up so as to complete the separation of the mass from below. In making the incisions up to this point, very little if any blood had entered the mouth, and it is desirable in doing this operation to provide against entering the buccal cavity as long as possible; but it was requisite at this stage to go into the month, and entering it from below I avoided trouble from the blood. Proceeding with the dissection around the lower large cyst, curved scissors were used, keeping close to the sac, while the whole mass was lifted upward so as to get a good view of the dissected structures; but notwithstanding all my precaution the sac was opened and the brownish fluid contents escaped in quite a stream from the external wound, thus lessening very notably the size of the tumor. It was thought best in view of this to cut through the coats of the sac, leaving the deep attachment to be dissected out after the diseased mass was so far detached as not to interfere with its removal. This portion of the sac in the deepest part of the excavation was in close proximity to the pharnyx, and in dissecting it from the surrounding tissues an arterial branch was cut, which was immediately seized with the forceps by my son and was subsequently ligated with catgut and dropped. It may be here stated that this was the only blood vessel which necessitated ligation in the course of the extensive incisions for the removal of the tumor.

I had provided an aneurismal needle armed with a strong silk ligature to secure the external or the internal carotid if the branches of either should be cut without being able to seize the divided vessels. The Pacquelin thermo-cautery was kept aglow by Dr. Davis to arrest any superficial oozing which could not be controlled by sponges with hot water. Thus, armed against any contingency I went forward with the excision from above, enucleating the upper cyst from the zygomatic fossa and the indurated mass of cartilaginous consistence from beneath the arch. Having completed the separation of the entire tumor, I was agreeably surprised to find that there was but little sanguineous exudation from the surface of the tissues involved in this deep incised cavern. The oozing soon ceased under the hot water applications and cleaning out the mouth and throat with a sponge probang,

the artery forceps were removed from the small twigs without any appearance of a jet of blood to require ligation. A loose compress of sterilized gauze was packed into the cavity with a strip out at the mouth. Depending upon the contractility of the skin to bring the flaps into proper relation for covering the wound, no part of it was excised, and the only notable fact upon bringing the cutaneous investment in apposition was the very decided lack of the normal temperature in the large upper flap. This caused some apprehension as to preserving the vitality of the tissues with the limited blood supply to the narrow base. But recalling an observation, in a plastic operation for building an artificial nose from flaps dissected out of each cheek, in which there was not only a loss of heat, but shriveling of the structure on one side during the first twenty-four hours and eventually complete restoration, I was hopeful in this case. The interrupted silk suture was commenced by me at the lip and by Dr. Gaston, Jr., at the remote end of the incision over the malar protuberance, bringing the parts accurately together so as to favor the restoration of the circulation at the earliest practicable period. After passing below the cuvilinear approximation, the union of the rectilinear incision along the former site of the body of the lower jaw, which had been removed, was affected with catgut stitches at a greater distance apart than the other suture. A broad strip of adhesive plaster was applied from the surface over the left lower maxillary along this line of catgut suture to the mastoid process on the right side to maintain a degree of fixidity in the parts.

The entire surface was covered with iodoform gauze and absorbent cotton, secured by turns of a roller bandage.

In the meantime, notwithstanding the slight loss of blood, there were such indications of shock as to require the resort to frequent hypodermic injections of whisky, alternated with nitro-glycerine and digitalis. The anæsthetic was discontinued after the detachment of the tumor, and vigorous measures were requisite to avert a fatal prostration. In addition to the above enumerated means, hypodermic injections of one-fiftieth of a grain of strychnine were repeated every half hour until one-tenth of a grain was given, and afterwards every hour until reaction was established.

After removing the patient from the operating table, bottles of hot water were applied along the lower limbs and on each side of the body continuously for several hours.

The pulse for a time was feeble and rapid, but five hours after the completion of the operation it counted but fifty beats to the minute, and the patient was still unconscious and in an extremely prostrate condition.

The favorable result of perseverance in the use of hypodermic injection of strychnine in this case adds another to the many instances in which this agent has been employed to avert profound collapse. While other drugs are transitory in their influence over the nerve centers, and should not be discarded in remedies for shock, there is nothing so trustworthy for its staying properties as strychnine.

I have no personal acquaintance with the virtues of camphorated oil, which Dr. Christian Fenger, of Chicago, and others have employed to a large extent under similar circumstances, but aqua ammonia strikes me as preferable to it. Having used the precaution of administering a hypodermic injection of morphine and atropine with a drink of whiskey to the patient before giving the anæsthetic of A. C. E. mixture, and there being less than five ounces fo blood lost during this operation, it was not anticipated that it would be followed with such marked vital depression. It is only a further illustration of the unknown factor which enters into the equation of shock, and there is no field of investigation which calls for the attention of the profession with greater urgency than this overpowering effect of surgical procedures upon the nerve centers. If the link of correlation between injury to the ramification of the nerves in the tissues and the great nerve centers was properly comprehended, it ought to throw some light upon the means to be adopted for the prevention of shock. After considerable study of the nervous system I realize the utter impotence of the operator in attempting to carry out any prophylactic measures against shock, and this subject is commended to the careful consideration of neurologists.

On the day following the operation there was considerable debility, but entire restoration of consciousness and ability to swallow fluids. The dressing was only lifted to ascertain the state of the upper flap, and it was found to have regained the

natural warmth throughout the entire line of union in the cutaneous wound.

During the second day there was marked reaction, and the traumatic fever was attended with a temperature of 102° F., and a pulse of 120 beats to the minute. The dressings having become saturated with the sero-sanguinolent discharge, were renewed, and the packing was removed through the mouth by drawing upon the strip which protruded. The entire inner surface was wiped off by a piece of gauze, wrung out of a mixture of one ounce of spirits of turpentine and one dram of camphor, and a tampon of the same left packed into the zygomatic arch and into the bottom of the cheek. All the tissues of the large upper flap were somewhat swollen and thickened, so that the space within was not so large as immediately after closing the wound.

Upon the third day the pulse reached 130 beats to the minute, and the temperature 103° F., but the general condition of the patient was good, and she drank milk with Mellin's food during the day. The dressings, not being much soiled, were not disturbed, and as the ligature in the tongue did not seem to cause any trouble, it was allowed to lay in the left corner of mouth loosely attached to the dressing. She took one-half ounce of Epsom salts.

On the fourth day the temperature ranged from 103° to 103.5° F., with a pulse varying from 130 to 135 beats to the minute. But the patient seemed hungry, and took, in addition to the Mellin's food, milk punch and chicken soup. She even craved bananas, but was not indulged in this. Her urine was normally evacuated. The dressing was all renewed, and the cleansing of the inside was repeated with the camphorated turpentine, but the packing was done with plain gauze. She had little difficulty in swallowing, and the bowels not being moved, the Epsom salts was repeated with good effects.

The fifth day brought no marked change in the condition of the patient, except that her pulse was weaker, and vital power seemed to be less, accompanied with some dullness of perception when spoken to. She was ordered milk punch at frequent intervals, and beef tea every three or four hours. The dressings were not much soiled, and were not disturbed. Her bowels had been moved on the previous day, and she had passed urine during the morning.

Upon visiting the patient on the following day, February 6, there was notable coma, with pulse of 110 beats to the minute and temperature of 110° F., and upon inquiry as to the discharge of urine it was found that none had been passed since the previous morning. Upon using the catheter my son drew off about two pints of urine, which presented nothing unusual in appearance, but no test of it was made.

Upon removing the dressing, the strip of adhesive plaster which had been carried from the left jaw along the line of incision to the mastoid process, was detached, and the union by first intention had taken place throughout the entire cutaneous wound. In removing the gauze packing through the mouth there was evidence of sensibility, notwithstanding the obtuseness of her mental condition. The interior surface of the wound was swabbed off with gauze wrung out of camphorated turpentine and packed as before with dry sterilized gauze with a strip protruding from the angle of mouth. This formed drainage, and was intended to facilitate removal of the tampon, should it have any tendency to drop back into the throat. The ligature through the tongue had not been required at any time to prevent this organ from falling into the fauces and obstructing respiration. But as it caused no trouble, the loop was allowed to remain in the left corner of the mouth, secured to the external dressing of iodoform gauze. She took milk punch after the dressing was completed, but there was some difficulty in swallowing it, due to the progressive coma. With a view to an alterative and tonic effect, the following prescription was given during the day:

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| | |
|---|---|
| Huxham's tincture | f ʒ ii |
| Tinct. nux vomica | f ʒ i |
| Chlorate potash | ʒ i |
| Water, q. s | f ʒ vi |

M. Sig.: Take a tablespoonful every three hours.

In the interval she was ordered to take whiskey toddy and milk punch.

There was a steady increase of coma, with a gradual decline of vital force until the death of the patient at five o'clock, P. M. of the same day, six days and four hours after the operation.

With the favorable state of the wound in the progress of this case, and the final retention of urine, I am disposed to consider the coma of uremic origin, but have no sufficient data upon which to base this opinion. The cause of death was given as septicemia in my certificate.

# OPERATION FOR ANCIENT DISLOCATION OF ELBOW AND BRIDGE OF CALLUS BETWEEN RADIUS AND ULNA.

JOHN B. ROBERTS, M. D., PHILADELPHIA.

The patient had an old dislocation of the elbow, which occurred two years ago, and was the result of a fall from a carriage, which was overturned. The injury was evidently a backward dislocation of both bones of the forearm, with compound fracture of the radius at the junction of the upper and middle third. The injury occurred two years before the patient, who is exhibited, came under my care at the Woman's Hospital. She at that time had the right arm rigidly extended with no motion at the elbow; suffered with pain and numbness in the fingers at the ulnar side of the hand, due to presence on the ulnar nerve, and had a suppurating sinus at the point of depression, shown in this cast made of the arm before operation.

It seemed to me that it was proper to attempt to treat the old dislocation, although of two years' standing, by making a resection in order to get the arm in a flexed position. I cut down upon the olecranon, and found that the head of the radius and the olecranon were soldered by callus, to the humerus, in the abnormal position. The ulnar nerve was displaced and in a condition of tension. I was compelled to chisel loose the radius and ulna and cut off the triceps tendon in order to put the bones at the elbow in the position of flexion, which would be so much more useful and convenient, even if the elbow were immovable. In order to unite the triceps tendon to the ulna after flexing the joint, I was obliged to lengthen it by cutting a V-shaped flap out of the tendon. This I did with its apex upward, and then turned the flap over with its point downward, and sutured it to the stump which had been left attached to the olecranon. I used silk sutures. I lessened the tension on the ulnar nerve by replacing it; in the course of a few days the numbness of the fingers disappeared.

In order to cover in the gap in the skin, I made a large plastic operation by dissecting a flap from the forearm. Her arm was now fixed at a right-angle, and in the course of, perhaps, two months, I got a considerable degree of motion. The radius and ulna were still united at the seat of the sinus by a bridge of callus, which prevented pronation and supination. I therefore determined to cut down and chisel out the bridge of bone and see if I could establish pronation and supination. Upon cutting down I found a sequestrum due to necrosis of the radius at the point of fracture. I chiselled away a considerable amount of bone and took out the dead portion of the radius. Knowing that the head of the radius would not be likely to rotate, as it had no cartilage upon it, I determined to make an artificial joint in order to get some pronation and supination in addition to the amount of flexion already obtained at the elbow. I excised three-quarters of an inch of the radius, and then encouraged the girl, after I had removed the portion of bone and the wound had partly healed, to make motions of rotation of the hand.

She obtained a certain amount of *passive* supination and pronation, and the fingers became more flexible. During our endeavors at making passive extension and flexion of the elbow, fracture of the ulna took place, some weeks later, in the upper third of the shaft. This necessitated putting her arm in a splint and prevented our continuing with the massage and other motions to get motion at the elbow and wrist. As the elbow would probably become stiff, I, in order to get the hand more toward the face, allowed the fragments to unite with a little angularity. You see now a bend or angular deformity at the seat of fracture, which enables her to bring the hand nearer the mouth than otherwise would have been possible. The wound has not entirely healed. She lost nearly all the flexion and extension she had from the first operation during immobilization of the joint for repair of the fracture of the ulna. She has a little motion at the elbow, not enough to be useful; there is practically no supination or pronation of the hand, but the numbness of the fingers is gone, and she can bend her fingers, which were stiff, pretty well. She has, and had, good motion at the wrist. We have not gained a great deal, therefore, except the right-angle position of the elbow, motion of the fingers, and freedom from pain and numb-

ness. If fracture had not taken place, I think we would have obtained considerable motion at the elbow, and have been able to maintain the false joint at the point of radial resection so at to give her some rotation of the hand.

The case is interesting to me because of the lengthening of the tendon of the triceps, the attempt to establish a point of motion in the shaft of the radius, when the head is adherent by ankylosis to the humerus, and the ease with which bridges of callus uniting the radius and ulna can be removed.

## DELAYED UNION IN FRACTURE.

THOS. G. MORTON, M. D., PHILADELPHIA.

In these days of antiseptic surgery, we are, perhaps, a little too hasty in regard to the treatment of delayed union in fractures, and do not give Nature time to effect repair. The length of time taken for repair was unusually long, yet the result in both cases here reported has been perfect.

CASE I.—*Delayed union in a fracture of the femur.*—(Notes of Dr. Wm. H. Shipps, of Bordentown, N. J.) On January 20, 1893, L. M., a young woman, seventeen years of age, while coasting, was violently thrown from a sled, sustaining a fracture of the right femur at about the junction of its middle and lower third. She was at once carried to her home, placed upon a firm mattress and sandbags and extension by weight and pulley employed. The patient, an intelligent girl, recognized from the start the importance of keeping the fragments in position, and labored in every possible way to avoid disturbance of the limb; so determined was she in this respect, that she avoided in so far as possible, a regular evacuation of the bowels, although assured of the folly of such a course. Having a most capricious appetite, it was difficult for the first six weeks to get her to take a sufficient quantity of nourishment, although the necessity for this important aid in bone repair was constantly urged upon her.

At the end of four weeks the dressings were removed and the limb carefully inspected. No shortening was detected, but to my chagrin, no attempt at union had taken place, notwithstanding the parts were in perfect apposition. The dressings were carefully reapplied.

On March 20, two months after the injury, an examination showed entire absence of bony union. At this juncture I requested Dr. Morton to see the case with me. It was agreed to resort to daily massage of the entire limb, especially in the vicinity of the fracture, and to lessen the amount of extension. The limb was also encased in a firm dressing made of two Russia felt splints; a posterior one, extending from the great trochanter to within six inches of the ankle; an anterior, extending the entire length of the thigh, firmly held in place by a roller bandage. Four weeks later the patient was allowed to get out of bed daily and walk about on crutches, care being taken that no weight be borne upon the limb. This plan of treatment was faithfully carried out; the appetite of the patient in the meantime materially improved.

In the course of three weeks the circumference of the limb had visibly increased, and an evident attempt at bony union noticed.

From this on the limb gradually improved in size and strength, until at the expiration of eight weeks from the commencement of massage, at which time Dr. Morton again saw the case, consolidation was complete. The dressings were continued for a few weeks longer, when a single roller bandage took the place of splints. Careful measurement of the two limbs at this time failed to show any appreciable shortening. Altogether the case made a most satisfactory recovery.

CASE II.—*Delayed union in fracture of the leg.*—On August 1, 1893, Captain A. S., aged fifty-one years, while at Ivigtut, South Greenland, in command of his vessel, received an injury to the right leg by the fall of a bulkhead or partition which separated the cargo of kryolite from the ballast; a medical man from the shore who was summoned, found the left leg seriously crushed, and an oblique fracture of both bones about the junction of the middle and lower third; he applied

temporary pasteboard splints, and the patient was hoisted from the hold. Four days later, bandages, pasteboard splints and a plaster dressing were applied. Three weeks later the swelling of the limb had so subsided that he observed not only a considerable movement, but a grating of the bone; six weeks subsequent to the injury the dressing was removed when it was found that there was little if any union; posterior board splint was applied, and two weeks later he left Greenland and arrived in Philadelphia on October 17th, seventy-eight days after the accident; he then entered the Pennsylvania Hospital. General condition good. The limb was greatly swollen, skin dry and rough, evidently no attention had been given to the condition of the circulation, for the limb had not been out of splints for many weeks, and had not been bathed since the accident; there was little if any effort at repair in the fracture. Attention was first directed to improving the circulation of the limb by soaking in warm water and by massage; fracture box; subsequently Russia felt splints; finally a brace was applied. He was discharged December 11, 1893, with considerable union, which was not firm until the close of January, when he was able to walk without any support.

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### A LUBRICANT FOR URETHRAL INSTUMENTS.

Prof. F. Guyon (*La Semaine Médicale*, No. 18, 1894) offers the following as an efficient lubricant for urethral sounds, etc.:

℞

| | | |
|---|---|---|
| Powdered Soap | 50 | 0 (℥j ¾). |
| Glycerine | | |
| Water, ana | 25 | 0 (℥vj). |
| Corrosive Sublimate | | 02 (gr. 1-5). |

This preparation is aseptic and does not irritate the urethral mucous membrane. It greatly facilitates catheterization of the urethra and bladder, as it is much more slippery than the substances usually employed: vaseline, oils, fats, and pure glycerine.

### MALE FERN IN HYDATID CYSTS.

Prof. R. Feletti (*La Semaine Médicale*, No. 18, 1894) claims to have obtained favorable results in three cases of hydatid cysts with the administration of the ethereal extract of male fern, in a day's dose of forty to fifty cgms. (six to eight grains); in these patients the cysts which were accessible to palpation rapidly diminished in volume, and in two the tumors completely disappeared under the influence if this drug.

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

### HYSTERIC MUTISM AND ETHERIZATION.

Drs. Fazio and Gioffredi (*La Semaine Médicale*, No. 24, 1894) cured a case of hysteric mutism in a young girl after electricity and hypnotism, both in the waking and sleeping states, had failed. Observing that though while awake she was not able to utter a sound, yet while asleep she had been known to utter articulate syllables and sounds. She was etherized. At the commencement of the procedure she began to cry, talk and complain that they were hurting her, etc. From that instant her disease was cured.

### CITRIC ACID IN DIPHTHERIA.

Dr. H. Laser (*Hospitals-Tidende*, No. 14, 1894) on account of the influence of citric acid on the micro-organism of diphtheria, recommends the following treatment:—Each hour the patient should gargle his throat with a dilute solution of citric acid, which is prepared by adding a teaspoonful of a 5-10 per cent. solution to a glass of water. In small children one may give a teaspoonful every hour or two. In the intervals let the children suck pieces of lemon or drink strong lemonade.

A FRIEND is worth more than a kinsman.—*Ex.*

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SATURDAY, JUNE 2, 1894.

## EDITORIAL.

### "WORDS FITLY SPOKEN."

Dr. Weir Mitchell delivered the annual address before the American Medico-Psychological Association, at the meeting recently held in this city.

His address was unique in that no time was wasted in laying any flattering unction to the soul. The truth, as the speaker saw it, was set forth in kindly but unmistakable language.

Dr. Mitchell's remarks were directed against the existing systems of management—or mismanagement—of institutions for the insane. But many of his criticisms could be equally well applied to other medical and charitable institutions which are organized on the same general plan.

Without any attempt to present a synopsis of the address, it is interesting to note a few of the just criticisms, the pertinency of which is not limited to asylums for the insane. For instance, he says:

"The mischief begins with the Boards. In some States the appointment and continuance in boards of a physician superintendent is said to be largely a question of politics. Can a man accept such office as a mere bit of party spoil and be fit for it? These Boards have to learn duties and acquire knowledge common enough among neurologists, but what governor comes to us and asks whom he shall appoint? That you depend on such bodies thus made up is a grave evil. Private or endowed asylums are no better off. A managing board has committees and these inspect, I really do not know how often.

"Could not these honest, right-minded gentlemen be brought to know how to do their work with intelligent care?

"What we want is a training school for hospital managers. In appointments I would stand on the scientific record of the physician alone if I had to be limited to one form of knowledge of a candidate.

"Permanent boards acquire the permanent disease of hospital torpor. The ailments of hospitals begin, as a rule, with the governing boards; they do not end there."

Of the special field of neurology as

exhibited in the management of insane asylums—the immediate subject of his criticisms—the speaker concludes that:

"As compared to the splendid advance in surgery and medicine of the eye, and the steady approach to precision all along the ardent line of medical research, the alienist's advance is proportionately little. In your work you have more and more drifted out of relation with the larger life of outside medicine and become a group of physicians who constitute almost a sect apart from our more vitalized existence.

"My fear is that some of you would not change your organization if you could. My belief is that your lives are destructive of energy. You are alone, uncriticized, unquestioned, out of the healthy conflicts and honest rivalries which keep us up to the work. The whole asylum system is in my opinion wrong and has been left to harden into organized shapes which are difficult to reshape. You ought not to live and sleep in your hospitals at all; you ought to be content with the world of sane men.

"In your reports I do not find the urgent repeated demands for obviously needed things. I find too comfortable assurance of satisfaction; too much stress on mere amusement; too little on rewarded work; too many signs of the contented calm born of isolation from the active, living struggle for intellectual light and air in which the best of us live. You hear the regret in every report that patients are not sent soon enough to asylums, as if you had ways of curing which we have not. Upon my word I think asylum life is deadly to many of the insane. You have long, and, as we think, unreasonably fostered the belief that there is some mysterious therapeutic influence to be found behind your walls and locked doors. There lingers a dislike to admit that mechanical restraint should never be used. We think it a question settled past argument. We think, too, of your locked doors and barred windows as being but reminders of that dismal system which we are pleased to think is gone forever. I presume that you have through habit lost the sense of jail and jailor which troubles me when I walk behind one of you and he unlocks door after door. Do you think it is not felt by some of your patients?

"Amid neurologists there is a settled belief that you do not handle your acute cases with sufficient individualization. Once we spoke of asylums with respect; it is not so now. You allow your managers to think you can be farmers, stewards, caterers, measurers, business managers and physicians. It is impossible. Some of you have shed this cumbersome coil of unprofessional business, but still feel overweighted; if so, you need help or are cursed by that slow atrophy to the energizing faculties which is the very malaria of asylum life. Asylum! there is despair in the name.

"When you find a case getting well, and let it go home, do you follow it with most anxious care to avoid relapse? As to the work for the chronic and convalescent, I never yet saw the hospital where all was done that can be done in this direction. I think there must be no effort to make this work pay. The noble object lesson seen at Wernersville, where hundreds of insane practically camped in the open and did work which would amaze many, ought to fill with shame the municipal authorities in this city when they look at our civic insane hospitals where rows of hapless men and women sit watched by attendants, untrained and unintelligent."

The address was delivered by special invitation and although the criticisms were keen and plain stated, the Association showed its appreciation of the sincerity and kindly intent of the speaker by promptly conferring upon him honorary membership in that body.

# ABSTRACTS.

## PRURITUS VULVÆ.

The persistent tickling, itching, and burning of pruritus vulvæ points not only to simple hyperæmic irritation, but to a more marked involvement of the skin-covering and its terminal nerve-bulb filament. Webster, on the basis of microscopic examination of excised portions of skin affected with pruritus, describes a subacute inflammation of the papillary bodies and advanced fibrosis of the nerve-endings, especially marked in the region of the clitoris and the upper portion of the smaller labia. These observations strongly suggest that the disease is in reality an inflammatory neurosis of the vulvar corium.

The severe forms are always associated with local lesion. Even though this is not perceptible to the casual examination, microscopic research will reveal thickening and infiltration.

The pruritus is usually caused by a local disease of the vulva. This region is swarming in germs. It is claimed that in diabetic pruritus the leptothrix and allied organisms occasion the deep skin inflammation, but others of the mycoses, such as that due to the oidium albicans, are often attended with itching.

Webster classifies the cases of pruritus as follows: 1. Endogenous cases. Under this heading are included those in which the blood is altered, as from icterus, chronic nephritis, diabetes mellitus, the waste products circulating in the blood acting upon the terminal nerve-filaments and occasioning itching. Under the same heading would be included the pruritus due to medicines, such as morphine, iodoform, alcohol, etc. Under the endogenous cases would also be classified pruritus caused by varices or congestion of the pudendal veins of the hemorrhoidals or of the pampiniform plexus, such as may come from a weak heart, pregnancy, hemorrhoids, or displacement or overgrowths of the womb. Moreover, certain well-known skin-diseases may occasion vulvar itching. Thus, erythema, herpes, urticaria, and certain forms of eczema may after an acute attack leave permanent alterations of the papillary bodies, which react upon the nerve-endings. Finally, fermentation in the intestinal tract may give rise to products which, absorbed into the blood, may act upon the nerve-endings. The frequent occurrence of constipation in women makes this a causative factor of no little importance.

Under the exogenous cases are classed those due to alteration or increased secretions of the vulvar glands, hyperidrosis, seborrhœa, polyuria with either altered or normal urine, diseased secretion from the vulva, vagina, and uterus, catarrh and suppurative secretions from the rectum, especially discharges from inflamed piles. These secretions are irritative partly from their direct chemical action, partly from their decomposition, irritant products being formed which act directly upon the macerated epithelium, causing erythema, intertrigo, eczema, and in certain cases prurogenous vulvitis. Causes of a parasitic nature are also frequently operative in causing pruritus. Thus, the pediculi, the ascarides, the oxyuris vermicularis, leptothrix, oidium albicans, micrococcus urænæ, gonococcus, smegma bacillus, the ordinary putrefactive bacteria, and the streptococci and staphylococci are said to be, if not the primary and predisposing, at least the secondary exciting causes of itching.

Of mechanical causes, masturbation will perhaps take the first rank; persistent washing and friction, especially when applied by means of sponges which are always unclean, encourages infection. The symptoms are aggravated by the scratching and rubbing occasioned by the symptom. Thermic influences are also operative; thus, there is a winter and summer pruritus.

Usually careful examination as to etiology indicates the most promising method of cure. Thus, where the disease is due to parasites, lack of cleanliness, to drugs, to decomposing discharges, to venous congestion, etc., the efficient treatment is obviously removal of the cause of the diseased local conditions. In those cases dependent upon visceral alteration, the local treatment must be subordinate to attention to the general condition. Thus, the appropriate regimen must be indicated in each instance in accordance with whether the patient be diabetic, jaundiced,

subject to Bright's disease, or suffering from venous congestion incident to heart weakness. The gouty or rheumatic diathesis must be properly treated.

Antiseptics as local applications are most useful. These are generally combined with astringents and with local anæsthetics.

Among the favorite methods of treatment are prolonged hot baths, followed by hot douches. These douches should be antiseptic and anæsthetic; thus, solutions of carbolic acid as hot as can be borne are of special service. It is noteworthy that the area affected by pruritus can stand a much stronger solution than can be used upon a healthy surface; thus, irrigations of 1 to 40 or 1 to 20 may be made. Bichloride is also serviceable, but the anæsthetic effect of the carbolic acid is lacking in this drug. A favorite prescription of D. Hayes Agnew, recommended as almost a specific in pruritus ani, is:

℞ Sulphate of zinc,
Alum, of each, equal parts.

To be mixed and heated until the water of crystallization is driven off. A drachm of this is added to an ounce of water and is applied locally. At times the carbolic lotion proves too irritating; then a simple astringent may be employed, such as fluid extract of hydrastis, 1 drachm to 1 pint, or hamamelis, fifty per cent., or even full strength. After prolonged douching, either with hot solutions of hydrastis or hamamelis, the parts may be bathed with a prescription made up of,—

| | | |
|---|---|---|
| ℞ | Menthol | gr. i. |
| | Cocoaine | gr. xxxvi. |
| | Alcohol | |
| | Water, of each | ʒi. |

Or an ointment may be applied made up of,—

| | | |
|---|---|---|
| ℞ | Menthol | ʒi. |
| | Simple cerate | ʒii. |
| | Oil of sweet almonds | ʒi. |
| | Carbolic acid | ʒi. |
| | Pulv. zinc oxide | ʒii. |

Or,

| | | |
|---|---|---|
| ℞ | Menthol | ʒi. |
| | Carbolic acid | ʒi. |
| | Lanolin | ʒii. |
| | Pulv. zinc oxide | ʒii. |
| | Unguent. zinc oxide | ʒi. |

Or a strong lotion of carbolic acid may be dabbed on, according to the following formula:

| | | |
|---|---|---|
| ℞ | Carbolic acid | ʒii. |
| | Glycerin | |
| | Water, of each | ʒix. |

Painting the vulva with glycerin mixed with a ten-per-cent. solution of chloroform and glycerin, with a ten-per-cent. solution of carbolic acid and glycerin and alcohol, or a solution of nitrate of silver of similar strength, is sometimes serviceable.

Madden recommends oleate of chloral painted over the parts. This is a compound formed of equal parts of camphor, chloral, and oleic acid. Where the disease is due to irritating uterine or vaginal discharges, he recommends the introduction of a tampon of cotton-wool loaded with equal parts of finely-powdered alum and sugar, and carried within the vulvar orifice. He holds that in his dispensary practice black wash is regarded as a most generally useful as well as a very cheap available application in such cases.

Goodell recommends a strong emulsion of iodoform and glycerin (ten to twenty per cent.).

Skene commends vaginal douches of acetate of lead, and dusts subnitrate of bismuth on the labiæ to prevent friction. This he holds is especially serviceable in diabetic cases. In the cases in which the etiology was obscure, he states that the remedies which have given him the best results are bichloride of mercury in emulsion of bitter almonds, one grain to the ounce, applied to the parts affected twice a day; a powder composed of one grain of morphine to two grains of chalk, applied night and morning; equal parts of tincture of opium, iodine, and aconite, and eight per cent. of carbolic acid, applied once a day; and ethereal solution of iodoform, applied by means of an atomizer. In some cases application of equal parts of carbolic acid and tincture of iodine relieved permanently. This was used in one case by means of an atomizer, the spray being driven under high air-pressure. An acute inflammation followed, but after the patient recovered from this the pruritus did not return. In certain cases, in spite of every local and general treatment, disease persists and renders life almost unendurable. Under such circumstances there remains surgical intervention.

Carrard reported the first case of surgical intervention. The clitoris was the part affected; its removal was followed by cure.

Schroeder carefully localized the points of itching, and then removed them by section in five cases. In one of these cases the disease was complicated by carcinoma. In another, in addition to excision of the diseased vulvar surface, a ring of skin was

taken from around the anus. In the three remaining cases the disease was purely pruritus vulvæ. In the first, a small area was removed from the right labium majus; in the second, the right labium majus was excised, and following this several lesser operations were performed; in the third, in which both the clitoris and lower lips were involved, the operation was more extensive. The women all recovered. The operator stated that intervention should only be attempted when the itching was localized, and cautions against attempting to cure a widely diffused pruritus by the knife.

Küstner also reports three successful cases.

Martin reports four, and a number of other operators state that the results were successful.

Sänger (*Centralblatt für Gynäkologie*, No. 7, 1894) contributes the full notes of two cases, both entirely successful.

He closes his thesis with the following statement:

The partial or total extirpation of the vulva is an entirely legitimate operation in cases of chronic pruriginous vulvitis not curable by other means. In younger persons the surgeon should be content with partial operation. In aged persons, when the disease is widely extended, the whole vulva, including the glans clitoris, should be entirely extirpated and the wound closed by plastic operation.—*Therapeutic Gazette.*

## THE ACTION OF LIGHT UPON THE DIPHTHERIA BACILLUS.

A recent number of the *Archives de Medicine Experimentale* contains an article by Dr. Ledoux-Lebard, detailing the results of experiments undertaken by the author for the purpose of ascertaining to what extent sunlight is effective as a means of destroying the microbes of diphtheria. The special purpose of the experiments was to determine whether the influence of diffused light is destructive of germs as well as the direct rays of the sun, as shown by Roux and Yersin. The conclusions to which he arrived are as follows:

1. The action of diffused light does not prevent the development of cultures of the diphtheria germ, either at a tempera ture of 95° or at ordinary temperatures. The direct rays of the sun arrest the development of the germs, and sterilize the culture medium in a few days. Diffused light has no bactericide power in relation to bacilli in neutralized bouillon, but has a marked bactericide power in relation to diphtheria bacilli in distilled water.

2. Diffused light kills dry cultures of diphtheria spread in thin layers, in less than two days (twenty-four hours' exposure to light).

3. The direct light of the sun acts in the same manner as diffused light, but with greater rapidity.

4. The bactericide power of light in relation to the diphtheria bacillus is due almost entirely to the most highly refracted rays of the spectrum.

5. The less refracted rays of the spectrum have little or no bactericide power.

6. Light, by virtue of its bactericide power, sterilizes in less than two days the bacilli of diphtheria, either moist or dry, and hence is a prophylactic agent against diphtheria.

7. In diphtheritic membranes exposed to the light, many of the bacilli are reached only by the light after it has lost a part of its intensity, and hence retain their vitality and virulence for a long time.

8. Light may be utilized in the disinfection of places contaminated by diphtheria.

The persistence of the virulence of the germs of diphtheria is well known, but a careful study of the classical examples of extreme persistence of this virulence shows that in the majority of cases, the contaminated objects had remained a long time protected from the light. In one case, for example, a brush which had been used for making applications to the false membrane of a child, communicated diphtheria to the father four years afterward, having been, in the meantime, wrapped in paper and placed in a drawer.

In other cases the means of contamination has been clothing which had been worn by a diphtheritic patient, and which had been protected from the light in a chest or closet.—*Modern Med.*

# SOCIETY REPORTS.

## PROCEEDINGS OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

*Meeting of 1894.*

[STENOGRAPHICALLY REPORTED BY L. C. ALEXANDER.]

The Forty-fourth Annual Session of the Medical Society of the State of Pennsylvania, was held in Philadelphia, May 15th to 18th, inclusive.

### TUESDAY MORNING.

The session was called to order by the President, Dr. H. G. McGormick, of Williamsport, at 10 o'clock.

Prayer was offered by Rev. A. B. Philput.

An address of welcome was made by Hon. Edwin S. Stuart, Mayor of Philadelphia, as follows: "Gentlemen, and Members of the State Medical Society: I was some time ago informed by a gentleman representing a large convention here, that one of the necessary evils of meeting in Philadelphia is an address of welcome by the Mayor, so I will not detain you long. I am glad you will meet in this city, for Philadelphia has been closely allied with the medical profession from its earliest days. As you all know the first hospital for the treatment of the sick was inaugurated in Pennsylvania on the application of Benjamin Franklin, and was erected in Philadelphia. From that time until now it has been doing excellent work.

"The first medical school, and the first school of anatomy were also inaugurated and located in Philadelphia, and for that it is a good reason why your society should meet here. From the time of the founding of these schools, the city has always maintained a creditable position. Philadelphia some time ago was made a place containing many colleges which were a disgrace to the city. They have been wiped out, and I hope never to see them again in Philadelphia, nor in the United States.

"I will not detain you longer, but, in the name of the people of Philadelphia, I extend to you a sincere and hearty welcome. And on behalf of your professional brethren of Philadelphia I also extend to you a hearty welcome, and I hope that the deliberations of your society will be of advantage to the medical profession not only in Philadelphia, but in America generally."

The address of the Mayor was followed by one of welcome by Dr. E. E. Montgomery, Chairman of the Committee of Arrangements. Dr. Montgomery spoke as follows:

"Gentlemen—As His Honor, the Mayor, has touched upon the medical side, it is my part to touch upon the political side. I welcome you to a new Philadelphia. You have seen in the papers the many measures that are being considered to add to the prosperity of this city. These measures are largely due to the gentleman who has just spoken, and his memory will long live in the heart of Philadelphia. We have quite a large programme to be gone over during this meeting, and added to this there have been a number of entertainments provided. In addition also, Philadelphia, with her usual hospitality, will throw open the doors of her hospitals, that the profession may see the latest methods of work. Dr. Roberts invites the delegates to his clinic, on Friday, at the Woman's Hospital. I will not detain you longer. You are welcome to Philadelphia, and we propose to make your stay as pleasant as possible."

Dr. William B. Atkinson, the Secretary, reported that there were fifty County Medical Societies in good standing, and that the State Society at present numbers twenty-five hundred members.

Dr. G. B. Dunmire, the Treasurer, reported the total receipts for 1894 as $4,122.24, and an expenditure of $2,423.45.

An invitation was extended to all members of the Philadelphia County Medical Society to attend the sessions of the State Medical Society.

The Committee on Publication reported that 2,500 copies, containing 300 pages of the report of the Transactions of the Medical Society for 1893, had been printed. Fifty-six of these copies had been distributed among the State Boards of Health, medical schools, and hospitals.

The report of the Committee on Scientific Business, Dr. C. W. Dulles, Chairman, was read and adopted.

Dr. J. A. Lippincott, of Pittsburgh, read the report of the Committee on the Prevention of Contagious Diseases of the Eye in Asylums.

Dr. John B. Roberts, of Philadelphia, Chairman of the Committe on Legislation, read the report of that committee, which was adopted.

The Society took up as new business, a series of resolutions referred by the Philadelphia County Medical Society, to the effect that the Trustees of the Journal of the

American Medical Association, in disobedience of the resolution of the Association adopted at the Detroit meeting, persist in publishing advertisements of secret nostrums.

The discussion of this matter was made a special order of business for Wednesday morning, following the paper of Dr. S. Solis-Cohen, "Should the Journal of the American Medical Association be used to Promote Quackery?"

Dr. I. C. Gable, of York, presented a resolution that, since the medical law of the State has been violated by the illegal registration of physicians, a committee of seven should be appointed to report on Wednesday, regarding the appointment of Inspectors, whose duty it shall be to aid the State Board of Medical Examiners in preventing illegal registration.

A preamble and resolution was presented by Dr. George M. Gould, of Philadelphia: "As it is admitted by all physicians that one-half of the blindness of the world is due to the disease called ophthalmia neonatorum, and as it is well known that treatment by a physician, if he is called sufficiently early in the course of the disease, always results in preventing blindness;—

"*Resolved*, That in the opinion of the Medical Society of the State of Pennsylvania, it is of the most vital importance to the welfare and happiness of the community and to the good name of the State of Pennsylvania, that the law recommended by the Committee of the Section on Ophthalmology of the American Medical Association, shall be adopted by the legislature of the State."

The law already adopted by five States reads: "Should both eyes of an infant become inflamed, or swollen, or reddened, at any time within two weeks of its birth, it shall be the duty of the midwife or nurse having charge of the infant to report in writing within six hours to the health officer, or to some legally qualified physician in the city or district in which the infant lives. The penalty for failure to comply with the law is made fine, or imprisonment not to exceed six months, or both.

The resolution was adopted and a committee appointed to present it to the State Legislature.

A resolution, presented by Dr. S. Solis-Cohen, that the Society is opposed to any revision of the code of ethics, was adopted.

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TUESDAY AFTERNOON.

The session was confined almost entirely to scientific business.

With reference to the proposed action of Congress to reduce the number of medical officers of the United States Army, a resolution, presented by Dr. Keyser, of Philadelphia, expressing the disapprobation of the Society, was adopted.

The address in Surgery was read by Dr. G. D. Nutt, of Williamsport.

Dr. E. La Place, of Philadelphia, read a paper on "The Radical Cure of Hernia." Dr. J. C. McAllister, of Driftwood, read an article on "Puerperal Eclampsia and its Treatment, Chiefly by the Hypodermic use of Veratrum Viride." "Modification of Pirogoff's Amputation" was the subject of Dr. F. Lemoyne, of Pittsburgh. Dr. J. V. Shoemaker, Philadelphia, gave some interesting "Clinical Observations upon Diseases of the Skin."

"Section of the Tendo-Achillis in Certain Fractures and Dislocations of the Lower Extremity," Dr. Thomas S. K. Morton, Philadelphia, was read by title. Dr. John B. Deaver read a paper on "Chronic and Recurrent Appendicitis." Dr. Orville Horwitz's paper was on "Treatment of Stricture of the Urethra." "Cramming in Medical Schools" was the title of Dr. O. H. Allis' paper. A number of papers were received and read by title, on account of the length of the session.

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WEDNESDAY MORNING.

The meeting was called to order at 9.30 A. M.

The report of the Committee on Nominations was announced as follows: *President*, John B. Roberts, of Philadelphia; *First Vice-President*, Dr. S. C. Stewart, of Clearfield county; *Second Vice-President*, Dr. J. A. Lippincott, of Allegheny county; *Third Vice-President*, Dr. J. H. Wilson, of Beaver county; *Fourth Vice-President*, Dr. R. Armstrong, of Clinton county; *Secretary*, Dr. William B. Atkinson of Philadelphia; *Assistant Secretary*, Dr. H. G. Chritzman, of Franklin county; *Treasurer*, Dr. G. B. Dunmire, Philadelphia.

*Members of the Judicial Council:* Dr. C. L. Stevens, Bradford; Dr. I. C. Gable, York; Dr. W. T. Bishop, Dauphin.

*Delegates to the American Medical Association:* Drs. J. K. Weaver, Montgomery; J. H. Vastine, Susquehanna; L. B. Kline, Columbia; G. H. Kirwin, Luzerne; J. F. Ross, Clarion; J. W. Hughes, Westmoreland; H. G. Chritzman, Franklin; William Anderson. Indiana; J. M. Beyer, Jefferson; S. Solis-Cohen, E. E. Montgomery and Edward Jackson, Philadelphia; I. Davis, Montgomery; D. M. Weidman, Berks; J. L. Ziegler, Lancaster; J. P. Simpson, Beaver; J. B. McAllister, Dauphin; S. M. Woodburn, Bradford; J. P. Getter, Mifflin; R. B. Hammer, Westmoreland; W. G. Gifford, Chester, and J. C. McAllister, Montgomery.

*Delegates to New York State Medical Society*, Dr. I. W. Groff, Montgomery; *New Jersey Society*: Dr. C. A. Rahter, Dauphin; *Mary-*

*land Society*, Drs. A. C. Wentz, York, and P. R. Koons, Cumberland.

Dr. William S. Foster, of Pittsburgh, read the Address in Medicine.

Dr. S. Solis-Cohen, in his remarks on "Should the Journal of the American Medical Association be used to Promote Quackery?" said:

"The question which I desire to present is of such great importance, the issues involved are so clearly defined, and the duty of this Society so obvious that I feel an elaborate argument would be out of place; that it would hinder rather than help the understanding of the subject, and I shall therefore content myself with a brief statement of facts. If I should make any error in the presentation of the facts I earnestly beg that I shall be corrected, as I desire to be unjust to no one. I would like to say also, that although the attempt has been made in certain quarters to convert this question into a personal question, it is not personal in any sense whatever.

"The trustees of the *American Medical Association Journal*, have committed to them by the American Medical Association, a deed of trust, and we find upon the pages of the Journal of the American Medical Association, advertisements of quack secret nostrums. Every reputable physician will say, 'Surely, the Trustees will not admit of such advertisements were they fraudulent,' and I believe many have been led to prescribe under the auspices of the Trustees. I am not criticising their personal conduct. I believe that official conduct would be a proper subject of public criticism.

"At the meeting of the Medical Society of Pennsylvania, held at Harrisburg, on May 18th, 1892, resolutions were adopted, disapproving of the practice of inserting advertisements of secret medicines in the medical journals. These resolutions were transmitted to the medical meeting at Detroit. In a meeting, crowded in anticipation of the subject, Dr. C. H. Thomas arose, and presented a resolution calling the attention of the Trustees to the violation. That resolution was unanimously adopted. It was received with such applause that no one dared to stand in the presence of his Fellows, for quackery! The Trustees then passed a resolution that any preparation, of which the formula could be communicated to their members, should be published—making all of us partners in this infamous business. I trust that the Medical Society of the State of Pennsylvania shall not be made a partner in the secret nostrum business, and I therefore ask that the Association once more record itself upon this question, and not only to enforce the resolution, but to instruct its delegates to take such action at San Francisco that will secure as Trustees of the Journal of the American Medical Association, men who will obey the resolutions of the Association."

Following Dr. Cohen's remarks, a series of resolutions, forwarded to the State Medical Society by the Philadelphia County Medical Society, condemnatory of the secret nostrum advertisements, and advocating their exclusion from the Journal of the American Medical Association, were discussed. [These resolutions were printed when adopted by the Philadelphia County Medical Society.]

Dr. C. H. Thomas, of Philadelphia, said: "I agree with all that Dr. Cohen has said. I do not see the face of one who I believe takes exception to what he has said. There are men here who were in Washington at the time of the organization and establishment of the Journal of the American Medical Association. Some of us remember that it was put forward as one of the best reasons for establishing that paper, that we would be sure of having an improved standard ethically. We have been treated to the singular spectacle of that journal going further than any other, in the practice of lining its pockets and helping to support itself by the contributions from quack medicines. We become partners under these circumstances, and every man must take shame to himself, unless he clear himself of this state of affairs."

A resolution was adopted that the Trustees of the Journal of the American Medical Association be informed that the American Medical Association prefers to have the publication of the Journal discontinued, if the money from quack advertisements is necessary for its maintenance. It was ordered that a copy of the resolutions of the Philadelphia County Medical Society be sent to each Trustee of the Journal.

Regarding illegal registration, resolutions were adopted that an accurate copy of registrations under the present law, on and since the first day of last March, and quarterly thereafter, in counties where there are no county medical societies, be forwarded to the Secretary of the State Board of Examiners, by the Secretary of each county society; and that where there are no county medical societies, a member living in the locality shall be appointed by the President to procure such list. Should such list not be sent, the State Board of Examiners shall be required to obtain the same. With the view of preventing disregard of the law, the Society appropriated $500 of its funds.

A resolution was adopted setting forth the advantages of an Epileptic colony, to be established for epileptics dependent upon the Commonwealth. It was ordered that copies of the resolution be sent to the Governor, the Speaker of the House, the President of the Senate, and to the President of the State Board of Charities.

Dr. Hildegarde H. Longsdorf, of Carlisle, read a paper entitled, "Christian Science in its Relation to the Medical Profession."

Papers were read by Dr. B. H. Detwiler, of Williamsport, and Dr. Charles Hermon Thomas, of Philadelphia. Others were read by title.

WEDNESDAY AFTERNOON.

At the opening of the session it was announced by Dr. H. G. McCormick, President of the State Board of Examiners, that the first examination under the recent law for license to practice in Pennsylvania, would be held simultaneously in Philadelphia and Pittsburgh, on June 11th. All applicants to be given the same questions.

Touching the appropriation for the support of the Library of the Surgeon-General's Office, at Washington, a resolution was passed urging Congress not to reduce the amount.

THURSDAY MORNING.

Under the head of unfinished business, Dr. S. S. Towler was appointed a member of the Committee on Scientific Business. Drs. Edward Jackson, H. F. Hansell, and J. A. Lippincott were appointed the Committee on Dr. Gould's resolution, by the President, Dr. McCormick.

A resolution was adopted that the Judicial Council of the American Medical Association be requested to take such action as necessary, in regard to the Trustees of the Journal of the American Medical Association, to sustain the integity of the Association and enforce the provisions of its code.

A resolution was adopted requesting the members of the Medical Council of Pennsylvania, and the State Board of Medical Examiners, not to use in connection with the Examining Board representing this Society, any sectarian title.

A resolution was adopted expressing the Society's approval of the establishment of a Bureau of Public Health, believing that the welfare of the country would be benefited; and asking that the passage of the bill be aided by the earnest efforts of our State representatives. It was decided to send to each Senator and Member of the House of Representatives at Washington a copy of the resolution.

An amendment to the By-Laws, providing that it shall be the duty of the Committee on Scientific Business to have the programme arranged and distributed within thirty days of the holding of each meeting, was offered by Dr. C. W. Dulles, of Philadelphia.

Papers were read as follows: The Address in Hygiene, by Dr. J. H. Wilson, of Beaver. Dr. A. M. Cooper spoke of "Psychical Phases in Married Tubercular Folk." "Prophylaxis in the Treatment of Tuberculosis," was the subject of a paper by Dr. Lawrence F. Flick. Dr. Flick's paper, and those of Drs. Hamilton, Thomas J. Mays, and others, bearing upon Tuberculosis, were discussed at length by Drs. S. Solis-Cohen, W. E. Hughes, J. C. Wilson, J. Solis-Cohen, J. M. Anders, and others. Dr. J. Solis-Cohen mentioned the desirability of mare's milk in the treatment of consumptives, from the fact that a horse was never known to have tuberculosis, and from the satisfactory results obtained from its use in the Home for Consumptives at Chestnut Hill.

THURSDAY AFTERNOON.

The Committee on Legislation was announced.

The President-elect, Dr. John B. Roberts, of Philadelphia, was introduced by Dr. McCormick. He took the chair and announced the appointments for the Annual Addresses of next year, as follows: Address in Medicine, Dr. I. C. Gable, of York county. Address in Obstetrics, Dr. W. B. Ulrich, of Delaware county. Address in Surgery, Dr. C. L. Stevens, of Bradford county. Address in Hygiene, Dr. Hildegarde H. Longsdorf, of Cumberland county. Address in Mental Diseases, Dr. F. X. Dercum, of Philadelphia county. Address in Otology, Dr. L. H. Taylor, of Luzerne county.

Adjourned.

**Anatomical Accidents.**

He kissed her passionately upon her reappearance.—*Jefferson Souvenir.*

She whipped him upon his return.—*Burlington Hawkeye.*

He kissed her back.—*Atlanta Constitution.*

She seated herself upon his entering.—*Albia Democrat.*

We thought she sat down upon her being asked.—*Saturday Gossip.*

She fainted upon his departure.—*Lynn Union.*

He kicked the tramp upon his sitting down.—*American Pharmacist.*

We feel compelled to refer to the poor woman who was shot in the oil regions.—*Medical World.*

And why not drop a tear for the man who was fatally stabbed in the rotunda, and for him who was kicked on the highway.—*Medical Age.*

Why not mention the fact of the man being shot in the water works?—*Cal. Med. Jour.*

How about the woman who was hurt in the fracas?—*Railway Age.*

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*A System of Genito-Urinary Diseases, Syphilology and Dermatology*, by various authors. Edited by Prince A. Morrow, A.M., M.D., Clinical Professor of Genito-Urinary Diseases, formerly Lecturer on Dermatology in the University of the City of New York; Surgeon to Charity Hospital, etc. Illustrated. In three volumes. Vol. II. Syphilology. New York: D. Appleton & Co., 1893.

As we have said in reviewing the first volume of the System, the articles represent the latest thought on the various subjects; and the men who write them, instead of scarcely being heard of till the appearance of the work, are men who stand in the fore front of the medical profession in the lines in which they have chosen their specialty. The editor states in his preface that "With the view of meeting the wants of the general practitioner, the subjects of diagnosis and treatment have received more consideration than is usually allotted to them in works of this class." The editor's promise has been carried out by the contributors—a point that we feel sure the general practitioner will appreciate.

The section on History, Geographical Distribution and General Pathological Anatomy of Syphilis is contributed by James Nevins Hyde, M.D. The author has long been occupied in researches as to the existence of syphilis in prehistoric times, especially among the aborigines of this continent, and in this article are given the fruits of his labors.

The Etiology of Syphilis is discussed by John A. Fordyce, M. D. From analogy with tuberculosis, leprosy, glanders, etc., the author concludes that syphilis is due to some micro-organism, though it cannot be proven with certainty till the discovery of the germ. After reviewing the failures in experimental inoculation of animals, the author concludes: "The future work in the etiology of syphilis must be directed to devising some staining method which will reveal the constant presence of the micro-organism in the products of the disease, and a culture medium upon which it will grow. When these conditions are complied with, opportunities may be afforded for inoculations which will conclusively demonstrate its etiological relationship to the disease."

The article on the "Modes of Infection in Syphilis" is from the pen of L.Duncan Bulkley, M.D. The article is intensely interesting, going into, as it does, the question of the innocent inoculation with the disease, as well as by the more usual channels—direct contact, mediate infection, hereditary transmission, and maternal infection. The author states that it is not believed that the normal secretions—milk, saliva, etc.—can communicate the disease, except when they act as the carriers of a pathological secretion from a syphilitic lesion. The article treats also of the acquirement of the disease through the daily duties of industrial and professional life, as instanced by the inoculation of glass-blowers through the blow-pipe and the physician in his maternity and gynæcological work. It is interesting to note what he says in regard to vaccination: "It is not believed that the absolutely pure vaccine lymph of the eighth day can communicate the disease, but that there must be an admixture of blood, pus, or some other element from the syphilitic person, in addition to the pure lymph. This may occur from the serum which oozes from the vesicle after the first portion of the clear lymph peculiar to vaccinia has been taken, when the surface is urged by pressure to yield more than the normal amount." In regard to razor wounds he says, "It is highly improbable that the razor plays any part in the event, other than causing the abrasion through which the syphilitic virus gains entrance." Indeed, he is rather inclined to doubt that the towels, soap and brush are the carriers of the contagion, but rather attributes the infection to the act of kissing, etc., at any house of prostitution that the subject may visit subsequent to the shaving. In some instances the infection undoubtedly took place from court-plaster which has been furnished and applied by a friend who used saliva to moisten it. The author is inclined to regard the infection of the woman through the semen possible—a theory that has been strongly denied by some—though he thinks it may also be accounted for by the view that a pregnancy of only a week or two duration has resulted from the union and that the woman has been infected through the ovum. We are sorry to note that the author has treated the subject of syphilis insontium, or syphilis innocently inquired, in a very few pages, referring the reader to his work on that particular subject.

The chapter on "Primary Syphilis" is written by Edward Bennet Bronson, M.D. The author would limit the term chancre to the non-infecting sore or the chancroid, designating the infecting or syphilitic sore by the term initial lesion of syphilis. This is on the basis of the meaning of the word chancre—destructive ulceration—which property resides more in the non-infecting than in the infecting sore.

Constitutional Syphilis has been assigned by the editor to Joseph Zeisler, M.D., while the editor himself, Dr. Morrow, describes Syphilis of the Skin, and Samuel Alexander writes of Syphilis of the Appendages of the Skin—the Hair and the Skin. Syphilis of the Mucous Membranes of the Mouth and Tongue is described by Charles W. Allen, M.D. Syphilis of the Joints, Muscles, Bursæ, Tendons and Aponeuroses is allotted to Frank Hartley, M.D., and to W. R. Townsend, M.D., has been given the chapter on Syphilitic Affections of the Bones.

The "Diagnosis and Prognosis of Syphilis" is the subject of an interesting discussion by Hermann G. Klotz, M.D. The author takes the common-sense view that the administration of specific treatment should not be begun

till the outbreak of such symptoms as make the diagnosis certain—in other words, until the appearance of the secondary lesions. The practitioner who sees much of venereal disease will often meet cases where he may feel positive that the sore is an infecting one and yet which will be followed by no symptoms of syphilis, even under no treatment whatever. In such a case it would have added immensely to the uncertainties of the case had the patient been put on antisyphilitic treatment so soon as the sore appeared, and neither physician or patient could ever have been sure that the sore was or was not an infecting one. The exception to this rule is where the seat of the lesions or their grave character demand immediate treatment even though there be a doubt as to their positive nature. The author affirms that syphilis is curable, this opinion being grounded on those instances where reinfection has taken place, since it is a well-known law that a syphilitic cannot be inoculated with the disease. The author affirms also that while the primary and secondary stages of the disease are constant, the tertiary stage is a much less constant consequence of the infection than the secondary; a large majority of the patients doubtedly escaping. In regard to the commonly accepted idea that extra-genital sores are more regularly followed by serious symptoms, the author states that his experience does not warrant any such conclusion. The prognosis of the disease to a certain extent depends largely on the habits of life of the individual, and the author warns against the use of tobacco by syphilitics on the ground that the lesions of the mouth are aggravated by its use. Alcohol is also to be forbidden, though it is a question whether it should be taken from a patient accustomed to its daily use. In such cases it would seem better to continue it in moderate amount simply for its supporting effect.

"The Treatment of Syphilis" is thoroughly described by Dr. J. William White in an able article. The author urges that every adult citizen should be made aware of the danger to himself and his family from syphilis, and every syphilitic should be told the serious character of the disease he is suffering from, and be made to realize that, except after certain intervals and under proper restrictions, his marriage is an outrage to the woman he professes to love, and a crime against society. The author also reviews the results in foreign countries of the police regulation of prostitution and the registration system in use in Paris, and recommends that prostitution be under state supervision. In this article are considered the advantages and disadvantages of the abortive treatment of the disease, and the author decides that the administration of mercury during the existence of the primary sore, unaccompanied by general symptoms, for the purpose of suppressing or aborting syphilis, is not justifyable, unless by confrontation the diagnosis can be confirmed, or unless there are urgent and unquestionable reasons for securing rapid cicatrization of the chancre. He considers the chances of preventing constitutional syphilis by cauterization or excision of the sore very slight, though it may be proper to employ such measures in a sore following intercourse with a person known to have syphilis. He regards the essential point in the treatment of syphilis to be the administration, during a sufficiently long period, of the largest dose of mercury which can be taken and absorbed without prejudice to the general health. In opposition to many, he considers the use of opium in conjunction with mercurials to be an unsafe practice, and especially does he oppose the use of Dover's powder advocated by Hutchinson. When it is necessary to counteract the griping and diarrhœa he prefers to prescribe paragoric, telling the patient to take only the smallest amount which will overcome the irritant effects of the mercury. His objection to the opium is that the secretions both of the skin and alimentary tract are lessened, and in this way the general health of the patient may suffer. Further than this there is nothing new in the article which describes the various methods of administering mercury, and also the so-called "Mixed Treatment." The hypodermic method is also carefully reviewed by the author, who rightly condemns it. He states his belief that "on the whole, while the final outcome of the experience of the last few years will doubtless be for the advantage of science and the extension of our therapeutic methods, the information thus acquired will be at the expense of many patients who will suffer from the direct consequences of the method itself, or succumb to the ultimate developments of insufficiently treated syphilis." In another portion of the article he asserts that "The hypodermic treatment of syphilis has not as yet shown results which warrant its adoption as a routine method to the exclusion of or in preference to other methods, but, on the contrary, has some apparently insuperable disadvantages and even dangers which render it improbable that it will ever be so adopted."

The earliest period at which a syphilitic may marry is placed by the author at four years.

The important subject of "Syphilis in Relation to Public Health" is placed in the hands of Samuel Treat Armstrong, M.D.

The chapter on "Chancroid" is written by Edward Martin, M.D. In it he still advises the treatment of the sore by cauterization. Many will question the advisability of this as the impression seems to be gaining ground in the minds of the profession that any irritation of the sore tends to bring about the complication of suppurative adenitis of the glands of the groin.

The want of space forbids more than the simple notice of the authors of the various other chapters of the work: "Visceral Syphilis" is described by W. T. Councilman. "Syphilitic Affections of the Rectum and Anus" by James P. Tuttle, M.D. "Syphilis of the Genito-Urinary System, Male and Female," by Eugene Fuller, M.D. Dr. B. Sachs contributes the article on "Syphilis of the Nervous System," while "Hereditary Syph-

ilis of the Nervous System" is from the pen of William N. Bullard, M.D.

"Syphilis of the Eye and its Appendages," both acquired and hereditary, is discussed by Dr. Charles Stedman Bull; and "Syphilis of the Ear" by Dr. J. Orne Green. The chapter on Hereditary Syphilis is contributed by F. R. Sturgis, M.D.

As is almost always the case in such works there is some little overlapping of the articles, but as a whole the work is singularly free from this fault. The editor is truly to be congratulated on his work. The presswork is particularly fine, and the publishers have evidently spared no expense to make the book attractive. The plates and illustrations are for the most part from photographs, and as a rule are original and prepared expressly for the book. Four of the plates are reproduced by photography and lithography combined, and the result is startlingly beautiful. Altogether the work stands a magnificent monument to American learning and art. It is not too complex to be of use to the general practitioner, nor too elementary for the specialist. To both alike it will prove of great value. The remaining volume of the series will be devoted to dermatology.

E. J. M.

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*Pain in its Neuro-Pathological, Diagnostic, Medico-Legal and Neuro-Therapeutic Relations*, by J. Leonard Corning, A.M., M.D., Fellow of the New York Academy of Medicine, etc. Pages 322, with 21 cuts in the text.

This book gives brief accounts of various diseases in which pain is a symptom of more or less prominence, and usually gives the means the author employs for its relief.

The principal novelty in the work appears under the head of Therapeutics—the author's method of applying analgesics by the galvanic battery; his application of drugs directly to deeply-seated nerves, the cauda equina, etc., by a long hypodermic needle; and an elaborate apparatus for (practically) applying dry cups to the jugulars, by applying compressed air to the entire body, and then bringing the skin over the jugulars in contact with the outer air.

S. M. W.

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# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

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THE TEXAS SANITARIAN

for April. Dr. Francis H. Atkins, of Las Vegas, New Mexico, writes about

**Pneumonia, especially Broncho-pneumonia, in New Mexico.**

This author thinks croupous pneumonia pretty closely confined to a belt of country extending north and south two or three hundred miles, along a line drawn from Cape Hatteras due west to the great plains. Men who live outside of this belt and yet claim to treat large numbers of cases of pneumonia, the author thinks, probably include in their lists a large proportion of broncho-pneumonia. He gives the differential diagnosis: a lobe uniformly affected in the one case, with a sudden onset from perfect health to a great rigor, with high fever, pain, hurried respiration, rusty sputum, etc. On the other hand, a case where typhoid fever, influenza, or some other depressing disease is followed by a cough, slight rise in temperature, dullness in spots of varying size throughout one or both lungs, most easily found posteriorly, varying in degree, and perhaps, the author says, in position from day to day.

Most authorities find the greater number of cases of broncho-pneumonia in young children. This has not been the experience in Las Vegas; but the cases which resulted seriously usually showed plain symptoms of tubercle, and were probably either tuberculous at the outset or caused the lungs to take on a condition favorable for the development of the more serious disease.

So far as treatment is concerned, the author believes in full doses of calomel at the onset, and the use of cotton, covered by oiled silk jacket, muriate of ammonia with ipecac as an expectorant. As cardiac and respiratory stimulants the author uses strychnia, nitroglycerine, belladonna, etc., sometimes finding caffeine very useful, sometimes very badly borne. Fresh air is, of course, very important.

Other papers in this issue are "Erysipelas," by Dr. N. B. Kennedy, a study of *Chaparro Amargosa*, by J. L. Pulegnat, Jr., Ph.G., and a letter from Dr. Arthur S. Wolff, in regard to the same drug.

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THE BROOKLYN MEDICAL JOURNAL

for May. Dr. E. A. Day has a paper on

**Recto-Colonic Alimentation.**

After concisely reviewing the steps his predecessors have taken in the direction of feeding patients through the rectum, he points out the requisites for a useful food for use in this manner: It must be a nutrient fluid, sterile, bland, absorbable, easily obtained and readily prepared. Failure to observe these points has been one reason that it has been heretofore impossible to support the life of a patient, by rectal feeding alone, for more than a few weeks at the outside. If the preparation used is not bland and sterile, we have, in a varying length of time, an attack of diarrhœa which prevents any further use of this means, and, if all of the injection is not absorbed, the residue creates an irritation which has the same result.

Another point brought forward is that the rectum is not suited for any purpose but that of excretion, and the mere presence of anything in the passage sets up involuntary ex-

pulsive movements; the colon, however, is quite different—it will readily contain several quarts of fluid, and in a reasonable time this will be absorbed.

Acting on the principles mentioned, the author makes use of a firm rubber tube about thirty inches long, fitted with a funnel which he fills with liquid at about the temperature of the body, and elevates enough to secure steady flow.

The tube need be introduced only from three to six inches within the sphincter ani, and, to show how much might be retained when given in this way, one case was mentioned which received and retained an average of eighteen ounces of fluid every hour for twenty-nine hours. At the end of this period the bowels moved freely, and an abundant excretion of urine occurred.

The preparations which Dr. Day is in the habit of using are the Liquid Peptonoids of the Arlington Company, and Panopepton of Fairchild Bros. He insists on the necessity of using from two to six ounces of sterilized water in every enema, and the use of a free enema some hours before an injection is given —even if it seem impossible that any residue can be in the bowels.

The length of time for which this method may be employed was well shown in a case, cited at some length, in which for a year, except during a few short intervals, it had to be mainly depended on to sustain life.

Other articles are "Methods of Drainage and a New Aseptic Drainage Tube," by Dr. Joel W. Hyde, and "Small-pox in Brooklyn," by Dr. F. A. Jewett.

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THE AMERICAN JOURNAL OF OBSTETRICS

for May. Dr. D. Berry Hart, of Edinburgh, contributes an article on

**The Extraperitoneal Form of Extra-uterine Gestation.**

While there is no doubt that the fetus is often intraperitoneal, this is no positive proof that the gestation is intraperitoneal. The position of the placenta alone determines the nature of the gestation, and the attachment of the placenta to the free surface of the peritoneum has never been demonstrated. The author states that evidence is now rapidly accumulating to the effect that extra-uterine gestation at or beyond the fourth month is extraperitoneal—*i. e.*, while the fetus may be intraperitoneal or extraperitoneal, the placenta is always extraperitoneal. In opposition to the older teaching on the subject, the author declares that the necessary elements for the placenta are on the one hand the fetal villi, on the other hand the connective tissue of the scrotina; that the covering of the villi is entirely and always fetal; and that the villi at their tips have an active phagocytic action. In the early tubal stages of extra-uterine gestation we do not know what relation the placenta bears to the epithelium, or whether, indeed, epithelium is present at the site of its earliest growth. In the latter stages, however, it develops entirely in relation to connective tissue. He therefore believes that the extraperitoneal development of the placenta is quite in accordance with modern views of the structure of the human placenta, and the belief that the extra-uterine placenta in so-called abdominal cases has developed on peritoneal epithelium is quite unwarranted.

While in the treatment of extra-uterine pregnancy no hard and fast rules can be laid down, there is no doubt in the author's mind that operative treatment is indicated, and that all attempts to cure by means of electricity, morphia, etc., are effete, or should be. While there is no difference of opinion as to the advisability of the removal of the fetus in the operation, considerable difference exists as to the placenta. The separation of the placenta in many cases has been attended by so much hemorrhage as to deter the operator. The author, in the present paper, records a case showing that this can be done with comparative safety when the iodoform tampon is employed, and that the placenta can be removed on successive days with advantage. Indeed, in certain cases, he does not see why the operator should not incise the sac abdominally and remove the fetus, plug the sac with iodoform gauze, and then remove the compressed placenta in a day or two.

In the case reported both fetus and placenta developed extraperitoneally. In all cases of extra-uterine gestation the site of the placenta determines the nature of the gestation. The fetus may become intraperitoneal after being tubal or extraperitoneal; but, as a rule which as yet knows no exception, the placenta, while arising in the tube and developing in the connective tissue of the pelvis, does not become intraperitoneal in the sense of ever grafting itself on the free surface of the peritoneum.

In conclusion, the author emphasizes his belief that the treatment of extra-uterine gestation must be operative, and that the operation should be undertaken as soon as possible. In early non-pediculated cases the fear of hemorrhage from the necessary separation of the placenta is irrational. The operator can separate and plug the sac with gauze; and if entire separation is impossible at first, it can be completed in a few days afterward. The opening in the sac should be left large, and it will be found that drainage goes on perfectly by means of the gauze until a glass tube can be substituted.

Appended to the paper is a report by Dr. Gulland as to the structure of the placenta removed by Dr. Hart.

**Clinical Contributions to Abdominal Surgery**

is the title of a paper by Dr. Paul F. Munde. The cases reported comprise the following:

1. Six cases of celotomy for ectopic pregnancy, all of which occurred during the past twelve months—four of them, indeed, with the mysterious habit of rare cases, within four weeks. All the patients recovered.
2. A large double pyosalpinx; recovery.
3. Epithelioma of the corporeal endometrium, with fibroids of the body; vaginal hysterectomy; recovery; relapse six months later.
4. Sarcoma of the body of the uterus, with small fibroids; complete abdominal hysterec-

tomy; practical recovery from operation; death after five weeks from the consequences of an old œsophageal stricture and gastric diverticulum.

5. Abscess of the ovary, with perforation into the large intestine; enucleation of the abscess sac; suture of opening in the bowel; recovery.

In the first two cases of extra-uterine gestation the diagnosis of unruptured tubal pregnancy was made, with almost absolute certainty. In the other four cases the probable diagnosis of ruptured tubal pregnancy was made, and verified by the operation. In no case was the fetus found. Curious to say, in five cases the left tube was involved; in one case only the right. The author states that he has, to his knowledge, seen but six other cases of undoubted ectopic pregnancy.

The author reports the case of double pyosalpinx as an instance of what he considers should be called by that term—that is, tubes distended with pus so as to form an appreciable tumor of oblong shape. The presence of a small amount of pus or muco-pus in an inflamed and hypertrophied tube does not, in his opinion, constitute a true pyosalpinx. True pyosalpinx he has not found to be very common. Tubes containing pus or muco-pus in so small a quantity as not to distend the tube, and apparent only after the tube is opened after its removal, are merely purulent salpingitis, not true pyosalpinx. The author thinks this distinction should be made, since the majority of cases of inflamed, hypertrophied, occluded and adherent tubes are of the latter variety, and do not represent tubes which are liable to rupture and cause fatal peritonitis. The author is also of the opinion that such tubes are not dangerous to life necessarily, and do not call for speedy or immediate removal. A tube distended with pus is always dangerous to life and indicates either removal by abdominal section, or, if adherent to Douglas' pouch and pointing at the vaginal roof, incision and drainage through that channel. When both tubes are distended with pus, whether loose or adherent, their removal by abdominal section is unquestionably the best and safest method.

(Many abdominal surgeons will take exception to the incision and drainage of pus tubes through the vagina, advocated by the author. We believe that the best treatment of true pyosalpinx, whether adherent in the pouch of Douglas or not, is their removal by abdominal section. We are sure by this means of removing all foci of pus, all collections of purulent matter, which cannot certainly be done by the incision and drainage method.—ED.)

In regard to the case of epithelioma of the corporeal endometrium, with fibroids of the body, the author states that the occurrence of fibroids with malignant disease is not by any means so rare as was formerly supposed. He has several times seen cancer of the cervix together with fibroids of the body; but the occurrence of fibroids and malignant disease in the body of the uterus is rather more rare, although there is no logical reason why a fibroid should not develop in the outer tissues of the uterus and malignant degeneration of the deeper structures occur subsequently. In this case the disease appeared to be limited to the uterine mucosa; but it must have been more deeply seated, since it reappeared six months after, in the cicatrix. The patient died one year after the operation. The ultimate result in this case has shaken the author's confidence in the radical cure of carcinoma uteri by vaginal hysterectomy. No more favorable case for a permanent cure could be imagined, he says, so far as previous examination could determine.

The article is illustrated with photographs of the specimens removed.

**The Antiseptic Treatment of Endometritis**

is discussed by Dr. C. S. Bacon. After discussing the microbic theory of the origin of inflammations, the author gives the following rules for the introduction of the sound, curette or any other instrument into the uterus:

1. Do not expect to complete the preparation of the patient with less than fifteen minutes of hard work.

2. Never make the examination at the first visit of the patient. Instruct her how to take a vaginal douche, and direct her to use sublimate douches twice a day for three or four days. If immediate examination is required, let it be done at her home or in a hospital, with all the preparatory details of a surgical operation.

3. Thoroughly disinfect the external genitals and surrounding skin.

4. Disinfect the hands and instruments, including the irrigating tip, which should be a glass tube.

5. Wash the vagina with a solution of lysol or creolin. A liquid soap, like Lee's or Johnstone's, is quite necessary. With two fingers, either with or without sterilized gauze or cotton, thoroughly scrub every part of the vaginal wall.

6. Introduce a Neugebauer speculum, which is better than any form of Cusco's bivalve, for it is asepticizable; and better than a cylindrical speculum, for it is much easier to work through.

7. Disinfect the cervical canal by means of a cotton swab, using first the liquid soap, then a strong creolin solution, and finally alcohol. Never introduce an instrument without seeing the cervical canal.

The author believes that the carrying out of these rules will prevent all except postpartum, post-abortum, and gonorrhœal endometritis and salpingitis.

The prevention of the extension of an acute gonorrhœal inflammation from the vagina to the endometrium is an important and serious problem. The tenderness generally prevents the thorough use of a vaginal douche. In children we must keep in mind the possibility of the irrigating tube being so firmly grasped by the vaginal sphincter that the fluid and secretion may be carried into the uterus; this can be prevented by providing a return flow. In addition to the use of the douche, every four to six hours a suppository of iodoform or bismuth subgallate can be used with advantage.

A useful adjunct to the various methods of treating endometritis, by means of applications, the curette, etc., is drainage; but gauze is, in the author's opinion, very poor material for a drain, the cross fibres keeping back or wholly preventing the flow. The author prefers wicking; but in the use of drainage he utters a note of warning in that the drain may furnish a ladder for the bacteria to enter the uterus, hence the vaginal end should be as well protected from the outside as possible by cotton tampons. While the value of drainage is unquestionable, he believes that many cases have been made worse by its use. This is because the plug of gauze acted as a dam instead of a drain, and because no attention was paid to the reverse current from the vagina. The curette is only one part of the treatment—simply an auxiliary to prepare for the antiseptic agent. In this respect it differs from the strong caustic, which has both a denuding and a germicidal action. When the curette is used carefully and thoroughly, however, and followed by an efficient germicide, the author believes that it is a more reasonable surgical procedure than the caustic. The debris produced can be at once removed and the extent of the curettage definitely controlled. The caustic causes a slough that must come away, and during this process there is the persistent danger of fresh infection.

Mild astringents or stimulants, like weak zinc chloride or iodine solution, are often harmful, because they serve as carriers of contagion; but when they are used with antiseptic precautions they may in suitable cases be of considerable benefit. The author regards their action as not solely nor chiefly antiseptic, but believes that they also modify the blood and lymph circulation and thus stimulate the antiseptic properties of Nature.

In speaking of the use of electricity in endometritis the author says: "A current of sufficient strength to have direct germicidal properties is too strong to be used in the uterine cavity. It is not advisable to use a current strong enough to produce a cauterizing effect. The galvanic current is a valuable agent in controlling hemorrhage, in cases of hemorrhagic endometritis, by virtue of its well-known effect on the circulation. The anode should be applied to the endometrium.

Dr. Joseph Eastman furnishes a contribution to the

**Technique of Suprapubic Hysterectomy.**

The great problem, in suprapubic hysterectomy has been what to do with the pedicle. In the method of suprapubic hysterectomy which the author has been working to perfect, it is sought to have no pedicle at all. For the last four years the author has also been trying to reduce the number of ligatures used. Recently he has devised an instrument, in appearance much like a gouge, which he states has enabled him to perfect his method of dispensing with ligatures, except those which tie off the ovaries, Fallopian tubes, and the upper part of the broad ligaments. The abdomen being opened and the broad ligaments tied off so as to secure the ovarian arteries, with button-pointed scissors he girdles the tumor below the place where the elastic ligature would usually be placed. He begins with these scissors and cuts around the line mentioned, drawing up the capsule anterior and posterior. He then peels down the capsule of the tumor and cervix with this gouge, as a glove finger would be pushed down and off with a spatula. He then passes his hysterectomy staff up the vagina, cuts into its groove, and draws a strip of bismuth subgallate (dermatol) gauze through the fenestra of the staff. Withdrawing the staff, the gauze is drawn down into the vagina. Then packing the pocket with the upper end of the gauze, folding the flaps of the capsule and uniting them with silkworm gut so as to secure sero-serous approximation with drainage from the vagina, he closes the abdominal wound, only keeping in a small Eastman drainage tube.

Dr. John T. Winter contributes a paper on

**Puerperal Eclampsia—Its Therapeutics.**

The author says that Bright's disease existing before pregnancy should not cause an unfavorable prognosis, and reports a case in support of this opinion. A knowledge of the premonitory signs is necessary to an early and successful adoption of preventive treatment, consequently the urine of the pregnant woman should be examined at least once every two weeks during the latter months of pregnancy, especially in those cases where there is œdema of the face, in primiparæ, and in those whose urine has at any time contained albumen. Having detected any of the well-known premonitory symptoms, we must vary our treatment according to the condition of the patient. If she is strong and plethoric, we should give an active saline cathartic and put her on an unstimulating diet. If, on the other hand, she is anæmic, a mild laxative and a nutritious diet should be ordered. If there is œdema with albuminuria, diaphoretics and diuretics should be given, jaborandi being, in the author's opinion, perhaps the best. The wine of colchicum, in as full doses as can be borne, is said to be an excellent remedy. The author also believes that cups applied freely over the kidneys might be of value in these cases. During a convulsive seizure certain precautionary measures should be adopted. The tongue should be properly protected from injury, the clothing should be loosened to prevent any obstruction to free circulation and respiration, and the patient be unrestrained as far as possible. In order to remedy any possible irritation from the presence of undigested food in the stomach, an irritant emetic should be given. Ten grains of the sulphate of copper dissolved in a wineglass of warm water, or the hypodermic injection of the one-tenth of a grain of apomorphia, will usually be found efficacious. If the irritation is in the intestine, or if there is constipation, a seidlitz powder, calomel, elaterium, or even croton oil should be given, or an enema of an ounce or two of Epsom salts in half a pint of warm water should be thrown as far up the bowel as possible. Cathartics do good not only by

unloading the intestinal canal, but by causing general as well as local depletion. The production of catharsis is the surest method of relief in dropsies, as well as in hyperemia of the brain, where cathartics do good not only by depleting but by acting as revulsives. In regard to the use of anæsthetics, the author advises the use of chloroform not so much during the paroxysm as in the interval, keeping the patient under its influence till the time of the expected recurrence is passed. By a judicious interruption of its employment it can be continued, in suitable cases, for twenty-four hours or longer; but it requires to be used with great caution, its exhibition being contra-indicated where the circulation is depressed or where there are any apoplectiform symptoms.

The various somnificants are also considered, and the author warns against the use of chloral in persons with weak or fatty hearts. Opium is also advised in the treatment of eclampsia. In convulsions from irritation following labor, as from a clot of blood in the cervical canal, the removal of the clot and the hypodermic injection of one-fourth of a grain of the sulphate of morphine is all the treatment that the author has found necessary in several instances. In regard to antipyretics, two fifteen-grain doses of antipyrin are reported to have caused the cessation of the convulsions in a woman six and a half months pregnant. She went to full term but the child was still-born. In regard to diaphoretics and diuretics, the author speaks of jaborandi as perhaps as safe in dropsies as any other remedy comparable with it in power. He further says that to him jaborandi seems to be the most valuable single remedy that we have as a prophylactic against puerperal convulsions. It produces excessive diuresis and diaphoresis, and proves a most valuable agent in relieving the dropsical accumulations. He has used the remedy in several instances with excellent results. Of the depressants he says that calabar bean is rather limited in its therapeutics. Nitrite of amyl may be useful after a paroxysm when the heart beat is almost imperceptible, on account of its power of dilating the blood vessels and increasing the heart's action. The remedy must not be pushed too far, nor must it be given when the face is flushed or if the pulse is full and strong, as it might produce not only uterine contractions but uterine hemorrhage as well. The bromides have superior claims as curative agents in puerperal convulsions, though the author would not like to discard either chloroform or morphia for them. He uses bromide of potassium because of its action as a sedative to the motor system, followed by general nervous sedation. The drug does not act during a paroxysm, but restores tone and diminishes the tendency to spasms. Veratrum viride and venesection are also discussed and the opinions of various observers quoted as to their usefulness.

Induction of labor should only be resorted to when there is no longer any possibility of saving both mother and child. The author advises the injection of an ounce or two of glycerin between the placental and uterine walls for the prompt induction of labor pains.

Dr. Casey A. Wood contributes a paper on

**Puerperal Panophthalmitis due to Septic Embolism,**

reporting a case. The author says that it is a fact not dwelt on in any of the text-books on ophthalmology, or even in the larger works which treat of the diseases incident to the puerperal period, that a woman, during or shortly after parturition, should be liable to complete loss of vision, in consequence of the carrying of detached intra-uterine particles through her circulation into the blood vessels of the eye. He asserts that the disease begins in the deeper structures of the eye instead of beginning in the superficial coverings of the eye and working inward, as has been taught. The prognosis, so far as the life of the patient is concerned, is always very grave. The case reported by the author is one of the very few on record where both eyes were affected and yet life was preserved.

Dr. Weller Van Hook discusses "Abscess Formation in the Patent Urachus," reporting a case. After discussing the pathology of the condition very thoroughly, the author gives, among other causes, the obstruction to the outflow of urine in post-natal life as responsible for the dilatation of a persisting duct to a channel of considerable size. The diagnosis of the case reported was made by exclusion. The treatment at first was daily irrigations with peroxide of hydrogen solution, with drainage by means of gauze introduced into the umbilical opening. Later, the opening was dilated and a small drainage tube introduced. The cavity closed in about a week.

Dr. Howard A. Kelly, in a paper entitled "The Advantage of Atmospheric Distention of the Rectum, with Dislodgment of the Small Intestines, in the Bimanual Examination of Uterus, Ovaries and Tubes," advocates the procedure, which is done by opening the anal orifice by means of a small speculum or tube, with the patient in the knee-chest position, thus allowing the rectum to become distended with air. By this means the author says that the rectal examination of the uterus and adnexa is rendered easier and diseased conditions are discovered more readily. It is needless to say that, before making such an examination, both bladder and rectum should be emptied.

Dr. Henry L. E. Johnson reports "A Case of Double Ovariotomy," and Dr. Grace Peckham-Murray concludes her paper on the "Mechanism and Treatment of Complete Procidentia Uteri," giving in this number the various methods of treatment advocated by different writers and operators. Massage has not been of much use in this condition. Alexander's operation is condemned. Ventrofixation and hysterectomy are regarded as too radical. The new operation devised by Freund is looked upon as offering good results. This consists in encircling the vagina with silver wire sutures, quilted in at equal distances, beginning near the cervix. The article is copiously illustrated with cuts of the various operations advocated by writers on the subject.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE

### Labor and Heart Disease.

Tarnier (*Jour. des Sages-Femmes*) notes that in heart disease all great and sudden efforts put the patient in peril, and labor is no exception to the rule. Running upstairs, racing to catch an omnibus or train and sexual intercourse may all cause fatal syncope. The danger of labor is not special in this sense; it is dangerous in heart disease simply because it involves much effort. Tarnier induced premature labor in a lady who was subject to advanced heart disease. Notwithstanding all precautions, she became moribund in the course of her labor. Directly she died, he turned and delivered a live child, which survived. A woman was brought into Tarnier's wards in January, 1894, in labor, with advanced heart disease and asystolism; she was apparently dying. Immediately about 300 grammes of blood were withdrawn, and the symptoms of suffocation diminished. The patient grew calmer. As it was extremely advisable to bring on labor quickly, as the forceps is apt to fatigue the patient, and as, in particular, the child was dead, the basiotribe was applied and delivery effected. A few days later the mother was doing very well.

### Follicular Tonsillitis.

℞ Olei Creasoti ..... gtt. viij.
Tinct. Myrrhæ
Glycerin ..... āā ℥ij.
Aquæ ..... q. s. ad ℥vij.
M. Sig.: Use as a gargle every two hours.

Professor Levy, in *Gross Med. Coll. Bulletin.*

### Whooping-Cough.

As a spray, Grasset advocates the use, from four to six times a day, of one or two teaspoonfuls of the following solution:—

℞ Phenosalyl ..... gr. xv.
Water ..... ℥ij.
M.

—*Le Progres Med.*

### Radical Method of Curing Corns Between the Toes.

Dr. A. M. Phelps advises that in case of corns between the toes, which after ordinary treatment recur, the skin between the adjacent toes should be entirely removed and the toes brought together by a line of sutures and allowed to unite. The webbing of the toes is entirely unimportant.

### A Rarely-Noted Symptom in Nervous Affections of the Intestines.

Dr. Lahnsen (*Muench. Med. Wochenschr.*) after describing the usual symptoms in so-called nervous dyspepsia, calls attention to a peculiar pain on pressure of the celiac plexus, which is commonly overlooked. This plexus lies upon the anterior wall of the aorta, immediately below and in front of the aortic opening of the diaphragm on the left side. The continuation of this plexus is the superior mesentric plexus which supplies the whole of the small and large intestines, with the exception of the rectum and descending colon. If we press downward from this situation, after previously emptying the abdomen, if necessary, the patient will invariably complain of pain. This pain, on pressure of the nerves on the left side, is a very characteristic symptom.

His method of treatment is as follows: He allows the patient a general mixed diet, forbidding only carbonic acid drinks and food causing flatulence. At night the whole abdomen is surrounded by moist towels, followed in the morning by cold rubbings, then a glass of a natural spring water, a walk and a light breakfast consisting of coffee, bread and butter. Later, electric or steam baths, followed by massage of the abdomen. After dinner, consisting of a mixed diet with a glass of wine, rest for one and one-half hours, followed by electric sitz-baths and gymnastics, with especial regard to abdominal movements. Supper at seven o'clock, at which one or two glasses of beer can be allowed. Patient to go to bed at 9.30.—*American Medico-Surgical Bulletin.*

### Bites or Stings of Insects.

A saturated solution of camphor or salol in ether may be applied with benefit. Or the spot may be painted with:—

℞ Collodion ..... ℥iiss.
Salicylic Acid ..... gr. xv.
Benzoic Acid ..... gr. xv.
M.

—*La. Med. Mod.*

### The Removal of Gunpowder Stains.

Dr. W. M. Nelson describes in the *New York Medical Journal* a case in which he employs the method of Dr. Ohmann-Dumesnil for removing the tattooing produced by explosions of gunpowder. The process consists of tattooing the affected surface with a glycerole of papoid. The case cited by the author was one in which the papoid was applied soon after the injury was received; and it would be interesting to know if the same process would apply to cases in which the pigmentation had been of long standing.—*Times and Register.*

### Phthisis.

Professor Bouchard prescribes:—

℞ Beech-wood Creasote..... 5j.
Balsam of Tolu..... 5i¼.
Terebinthine ..... ... ..... gr. xv.
Benzoic Acid ..... q. s.

M. Make into 80 pills, and let 10 pills be taken daily.

Or,

℞ Beech-wood Creasote..... 5iss.
Codliver Oil..... Oi¾.

The formula for hypodermic injection devised by Morel-Lavallee is:—

℞ Iodoform..... 5j.
Guaiacol ..... 5i¼.
Eucalyptol..... 5iij.
Sterilized Olive Oil..... 5ij.

M.

To relieve cough Grasset gives the following pill:—

℞ Terpine..... gr. iij.
Codeine..... gr. 1-6.

M. Four or five such pills may be taken daily.

In the chronic form with adenopathies Grasset prescribes:—

℞ Iodide of Sodium..... 5iiss.
Bromide of Sodium..... 5v.
Chloride of Sodium..... 5x.
Water..... 5ix.

M. Sig.: Teaspoonful in a glass of milk morning and evening.

—*Le Prog. Med.*

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### A New Method of Treatment for Tonsillar Hypertrophy.

Ruault describes his method of removing hypertrophied tonsils. He claims it is superior to both the tonsillotome and ignipuncture in cases where such methods are usually employed. It does not cause bleeding like the former, nor pain, either immediate or consecutive, as does the latter. It enables one to operate with a precision and surety lacking in other methods. Cocaine having been applied to the tonsil, any crypts containing secretions are cleaned out, and such adhesions as may exist between the tonsil and soft palate destroyed. By means of a cutting forceps, one blade of which is flat and fits into the opposite one, which has a sharp cutting edge, small pieces of the projecting tonsil are then removed. After several pieces have been cut off, the raw surface is energetically rubbed with a swab of cotton moistened with iodine one part, iodide of potassium one part, and water six to eight parts. The discomfort arising from this passes off in a quarter or half hour. In a few days secondary reaction will have reduced the size of the remainder of the tonsil and, if necessary, any projecting pieces may be removed as before. Of eighty cases treated by the author in only three was there a necessity of operating a third time, except in the case of infants.

### The Dangers of Cocaine

Are recapitulated in the *American Journal of Ophthalmology* in a paper by Dr. Albert R. Baker, of Cleveland, who collects a list of ten fatal cases of poisoning by the drug. The smallest fatal dose where a measured quantity was given was two-thirds of a grain, which was injected into an eye with the result that immediate unconsciousness was produced, followed by death in four hours. One grain injected into the gums by a dentist produced death in a few minutes. The application of a ten per cent. solution to the larynx with a brush was also fatal, unconsciousness following almost at once and death in three hours. The author also reports a case where the instillation of a six per cent. solution into the eye was followed by alarming depression, with periods of unconsciousness attended with delirium. Other and similar cases have been reported.—*Northwestern Lancet.*

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## SURGERY.

### Gonorrhœa.

A new specific for gonorrhœa is a 1 per cent. solution of creasote in decoction of Hamamelis combined with Boric Acid. It is claimed that this will destroy the gonococci in two hours.—*Pacific Medical Journal.*

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### Rubber-Tissue Gloves for Protecting the Hands during Operations, etc.

Dr. T. S. K. Morton has called attention to thin rubber gloves, which have been in the market for some time and are coming into use for general surgical purposes and for handling strong solutions. "I have found these rubber-tissue gloves extremely useful in handling offensive cases. With them it becomes a pleasure to make rectal examinations, because the skin of the hands does not become saturated with fetor, and it is wonderful how many more examinations one makes. Also in handling strong solutions, or even in operating upon septic cases they have an excellent field. The rubber is so very thin that it interferes very little with the tactile sense. As a rule, they go on with great ease and come off readily. The dealer said he was not sure that they would last very long in handling instruments, but thus far I have used them considerably, and they are still practically in perfect order. But if they could be used only a few times, the price, $2.50, with 40 per cent. discount to hospitals, is not excessive. I think them of great value when handling morbid growths, or making post-mortems, where it is possible to be inoculated. They bear steam sterilization and soaking in strong solutions of carbolic acid or bichloride."

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### IMMEDIATE CAPSULOTOMY FOLLOWING THE REMOVAL OF CATARACT.*

L. WEBSTER FOX, M.D.,† Philadelphia.

All ophthalmic surgeons endeavor to obtain perfect vision after the removal of a cataract. On account of its prevalence, the loss of one of the most valued of the senses, and the restoration to vision by a bloodless and painless operation, have concurred to render this operation an object of the highest attention to surgeons; and the progress of improvement in the operation has been commensurate with the advances made in surgery elsewhere in the economy. Unfortunately, with all our skill and knowledge, success does not always follow the removal of an opaque lens. The many contingencies incident to the healing of the wound, the distortion of the cornea, the subsequent change in the media caused by iritis, or a thickening of the posterior capsule—one or all of these factors play a very important role in the subsequent restoration to vision.

The opaque lens, with its capsule, obstructs the vision, causing blindness of the patient. To remove this obstruction requires considerable dexterity; to restore vision, absolute cleanliness and most careful after-treatment. The most disheartening factor in a cataract operation is that sooner or later the posterior capsule thickens, and again dimness of vision follows; the lessening of the sight is not so great as it was before the removal of the lens, but still the patient is debarred the comfort of reading, writing, or attending to business matters in which it is necessary to have perfect vision. It is to prevent this latter change that I advocate the splitting or parting of the posterior capsule at the time of the primal operation.

Having had the opportunity of following many operators, good, bad, and indifferent, and noting the after results, I frequently saw excellent vision follow bungling manipulation. The surgeons did not possess that delicate sense of touch so essential in making the corneal incision, snipping the iris, lacerating the anterior capsule, and delivering the lens. They lost courage, or their hand became so tremulous after they had ruptured the capsule, that the operation would have been a failure had they not taken a lens scoop in hand, entered the eye, and fished out the cataract and its capsule, with always more or less loss of vitreous. With very great care in the after-treatment, many of these patients would recover, and in the majority of cases which did recover, no capsule interfered with their visual acuity. It was witnessing such operation that led me to think that a parallel process, carried out, however, on more delicate operative lines, at the time of the primary operation, would still lessen the dangers that such harsh measures would be sure to excite.

The ancient method of removing cataracts from the direct line of vision was by *couching;* that is, passing a delicate needle through the sclerotic coat on the temporal side of the eyeball, posterior to the ciliary bodies; pressing it forward and into the

* Read before the State Medical Society of Pennsylvania, May 17, 1894.

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crystalline lens. Then, by a backward sweep of the point of the needle, lens and capsule were torn from their position and deposited down and out in the vitreous chamber. Celsus, the celebrated Roman physician, who lived at or about the commencement of the Christian era, describes, and is generally esteemed the father of this operation. It was not very satisfactory in its results, according to the data obtainable from the earlier writers. Fabricius, who flourished in 1600, speaks with great despondency of this operation; later on, Hiester, 1711, says: "Though the operation is easy to be performed the success is so very precarious, that amongst a great number of persons couched by the most distinguished oculists, very few met with the desired results; and upon the vast number of patients upon whom the celebrated itinerant, Taylor, operated, not one in a hundred recovered his sight." He further says, "that in several different places he saw many miserable objects in tormenting pain, arising from inflammation consequent upon the operation, and that of those who regained their vision, there was scarcely one in ten who did not sooner or later lose it again." For eighteen hundred years this puncturing of the eyeball, with its most deplorable results, was the only method held out to the blind. It was the outgrowth of an accident which gave birth to the rival plan of extracting the opaque lens through an incision of the transparent cornea. It was the failure to remove a cataract which had escaped into the anterior chamber by couching, that led M. Mery to recommend, in the year 1707, the practice of extraction in all other cases of this disease. It was left, however, for Daviel, the celebrated surgeon of Paris, 1745, to bring forward this method as one infinitely less dangerous than couching. From that day to this the incision is made through the cornea, or along its margin, and the percentages of loss is to-day what the gain of vision was one hundred and fifty years ago.

### PRELIMINARY TREATMENT ESSENTIAL IN CATARACT OPERATIONS.

I deem it of the greatest importance to interrogate all cataract patients presenting themselves for an operation, as to their general habits and family history, and to make a careful examination of the urine, restricting meat diet and increasing a vegetable one; while last but not least, placing the patient, one week before the operation on the mixed treatment, also paying particular attention to bathing both eyes with a boracic solution containing sulpho-carbolate of zinc; examining the eyelashes and particularly the nasal cavities. If any catarrhal affections are found in these cavities, it is of paramount importance that they receive the proper treatment before an operation is performed. The day before the operation, the patient is given a warm bath and a saline purgative, kept in bed, and his face washed with castile soap and water, then washing the skin around the eye to be operated upon with ether, following this again with a 1:5000 solution of corrosive sublimate, after a German method (Schweigger).

The reason I call attention to these minute details is that the patient may suffer from some defect which would not affect an eye in a comparatively healthy state, but might exercise an extremely pernicious influence on the eye after the irritability following the operation. The effect to be dreaded is inflammation, and therefore every measure calculated to prevent its occurrence must be taken. There are still a few ophthalmic surgeons who think it quite unnecessary to take these preliminary precautions, but, happily, the number is growing less year by year.

At the time of the operation, still greater precautions are taken; the patient's face, neck and mouth are thoroughly cleansed; clean underclothing, over which, and fitting close to the neck, a sterilized sheet is wrapped; head bandaged in a sterilized towel, and the eye irrigated with an aseptic fluid, as hot as the patient can bear it. The instruments are also sterilized; all fluids, such as atropine and cocain, are sterilized in a Llewellyn flask. The operation is performed then in the usual manner.

After the delivery of the lens (cataract) and all cortical matter is washed out of the anterior chamber, I proceed with the rupturing of the posterior capsule—the subject of my paper. The instrument used is a gold enameled hook, made as delicately as is consistent with keeping its shape. It is of malleable steel, so that it may be bent to any angle which I find is convenient, especially when the eye of the patient lies deep in the orbit. The hook is passed into the anterior chamber,

and behind the lower pupillary margin of the iris, on its flat side. It is then rotated backwards, hooked into the capsule, drawn gently upwards to the mouth of the incision, rotated on its flat again, and then taken out of the chamber. By this means, the capsule is torn, and the vitreous presses forward between the rent. Very little or no vitreous shows at the mouth of the wound. If it does, I snip it off.

When the operation is performed after the simple method (without iridectomy) the same manipulation is carried on with but one exception; and that is, the line of incision is not so long. The ophthalmostat is removed, and the eyeball again irrigated with hydrostatic eye-douche, followed by dropping one drop of sterilized Atropia solution into the eye; the lids closed and thickly anointed with vaseline, which has been sterilized by boiling; over this, specially devised eye-pads, which have also been sterilized by heat, held in place by adhesive strips, which keep the bandages, securely fixed, permitting the patient to change his position in bed as often as desirable. In twenty-four hours the dressings are removed, and both eyes bathed with warm water, and irrigated with the sulpho-carbolate solution, another drop of Atropia applied, and similar eye-pads adjusted with as much care as at the primal operation; and so continued from day to day until the eye is out of danger.

Is this a new operation? Some of the older writers of fifty years ago, hint at the removal of the lens and its capsule, but they are not explicit enough to say that they did so. The only authority that I can find saying so positively, is Richard Middlemore, who on page 138, Vol. II, in his great work on "Diseases of the Eye," published in 1835, after speaking of the removal of the lens, when the pupil is not clear, on account of the thickening of the posterior capsule or the hyaloid membrane, says: "In every such instance, I have found it absolutely essential to the successful result of the case, to lacerate the posterior capsule and hyaloid membrane, and permit the escape of a portion of the vitreous humour." Coming nearer to our own day, I must say a few words about the distinguished surgeon who left his impress upon all who witnessed his wonderful skill as an operator. I have reference to the late Dr. Richard J. Levis, of this city. I have had the opportunity of examining quite a number of patients, from whom cataracts were removed by this eminent surgeon. In nearly every instance the posterior capsule was evidently ruptured at the time of primal operation. Whether this was a constant practice of Dr. Levis' I am unable to say, but I am sure he realized the importance of removing the posterior capsule at the time of the original operation. Pagenstecher, of Wiesbaden, is also an advocate of removing the lens and its capsule at one sitting. Hasner, another German ophthalmologist, is an advocate of this radical operation. It has recently come to me indirectly, that Dr. Knapp, of New York, is also lacerating the posterior capsule at the first operation.

Is the operation always successful? Laceration of the capsule alone does not prevent the hyaloid membrane from becoming slightly translucent. When this takes place, we may follow with a needle operation, and not provoke cyclitis by trying to tear a tough, inelastic tissue.

I have been in the habit of performing this operation in alternating cases, for ten years. In those patients upon whom the operation was performed, I had to repeat a needle or capsulotomy (scissors) in about fifteen per cent. of the cases. Where it was not performed, in about seventy-five per cent. In the fifteen per cent. of the cases where it did not succeed, I can only attribute it to a very thick posterior capsule, the vitreous receding after closing of the eye-ball, and thereby not keeping the capsule separated, but practically closing again. My experience has led me to believe that there is less danger of inflammation of the eye-ball in immediate capsulotomy, than in a subsequent operation.

The elder operators recognized the gravity of puncturing an eye-ball with a needle, and hailed with delight the improved method which completely revolutionized statistics. My own experience is fast leading me to adopt the cutting through the cornea with keratome and the incision of the capsule with a De Wecker's scissors, disregarding the needle altogether. With the preliminary treatment, and with the aseptic methods now employed, success is almost always assured; whilst with the treacherous needle, almost every surgeon has had reason to regret this modus operandi in more ways than one.

# BATHING, SWIMMING, AND DIVING AS CAUSES OF AURAL DISEASE

LAURENCE TURNBULL, M. D.,* Philadelphia.

Before entering into an account of the manner in which the ears of bathers are affected, it will be of interest to consider the construction of the ear in animals living a portion of the time submerged in water. A large number of marine quadrupeds may be included in this class, such as the crocodile, seal, hippopotamus and the like. These animals can remain under water a long time before coming to the surface for the purpose of breathing, and it is found that the construction of their ears is such that no damage occurs to the organ from frequent excursions under the water, which is colder than the surrounding atmosphere and would be irritating to delicate structures.

Some of the lower orders of marine life living exclusively in the water, have no special auditory nerve but receive sound impressions by means of shock imparted to the body.

The tympanic membrane and other parts necessary to sound transmission in mammalia are said to be absent in snakes and many saurians, though lizards and frogs have an exposed drum-head. Moles are said to have a closed external auditory meatus which excludes earth in burrowing; and the camel when exposed to the sand-laden simoon of the desert has the ability to contract the nostrils at will.

Swimming and diving in cold water is a frequent cause of disease of the external auditory canal and external surface of the membrana tympani, as also of the middle ear, though bathing in river or sea water is, when wisely and properly regulated, both healthful and pleasant. The evils attending bathing and swimming in cold water are the entrance of this cold fluid, not only into the external meatus, but as far as the membrana tympani, causing inflammation of the lower portion of the auditory canal, and of the anterior surface of the tympanic membrane. A still greater evil is from sudden deglutition, *i.e.* making the effort to swallow during diving or swimming, by which—the mouth, nose and pharynx being filled with cold water, and the mouths of the Eustachian tubes open—a portion of water passes into the middle ear. This result rarely occurs in expert swimmers and divers, but is most common in beginners, who from cold, or the shock of the contact with the water suddenly breathe or swallow in a sobbing manner. We have, however, known it to occur in old and experienced swimmers while plunging head foremost, termed a "header," owing to the intense coldness of the water the act of deglutition being involuntary. Bathers in the surf are liable when off their guard to be struck by the waves upon the ear with much violence, especially in boisterous weather at full tide. Cold salt water may thus enter the external auditory canal with sufficient momentum to rupture the drum-head, especially in persons having a large, freely open canal. Swimming or floating upon the back, especially the latter, when the ears are submerged, or diving and swimming beneath the surface, often exposes the ears very much to the entrance of the water.

The lovers of sea-bathing will learn with much interest the result of a series of observations on the temperature of the sea, which were completed some time since by the Scottish Meteorological Society. The observations were made every day during a period of four years and nine months, and the result was to confirm the impression that the changes of atmospheric temperature influence the sea but slowly. The variations in the warmth of the sea-water occur within a range one-third less than that of the air; and the mean temperature of the sea is found to be warmer than that of the atmosphere in seven months out of the twelve. The summer warmth penetrates the sea very gradually, and is more gradually given off. January is the coldest month, but the sea-water is coldest in March. July is the hottest month but the sea-water attains its maximum warmth toward the end of August. From that time the sea becomes warmer than the air, and cools so much slower than the weather that in November the average warmth of the water is six degrees, and in December seven degrees, higher than that of the atmosphere. The balance is reached at the end of March,

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and then for the next five months the air is warmer than the water.

These figures, which result from careful observations made at Peterhead, justify the custom of extending sea bathing late into the autumn. Sea bathing should, in fact, begin late and may safely end late. It is more dangerous in the warm days of early summer than in the chilly days even of the late autumn. The sea is as warm at the end of October as it is in the second week of June, and the period between these two dates is the healthy bathing season for those who are strong enough to begin early and leave off late.

If the water is not removed by placing the head to one side, and drawing the external ear forcibly outwards, shaking the head at the same time and opening the mouth, also striking the external ear with the palm of the hand, it is apt to cause inflammation as the water decomposes, followed by perforation of the membrana tympani; or, the inflammation with the formation of pus, if neglected, may pass inward to the middle ear, cochlea and labyrinth, and implicating the brain, may terminate in death.

It is a well recognized maxim among those who devote special attention to diseases of the ear, that no cold fluid should be allowed to enter even the external auditory canal; still this important fact is not sufficiently recognized by the profession at large. The entrance of warm water into the ear is less objectionable, but even this is not quite free from danger, and has its disadvantages; and the water should in all cases contain a few grains of saline ingredient, like borax, soda, or common salt, a teaspoonful to the pint, when employed in washing out the ear. The symptoms of water in the middle ear are, in the first stage, an uncomfortable sensation followed by earache or pain, which after a time, if neglected, becomes agonizing, and is accompanied with great tenderness behind the auricle. In proof that water in the ear is injurious and causes deafness, we might cite a number of instances. It is a well known fact that dogs which are *thrown* into the water become deaf.

Many cases of this form of disease in its chronic stage, come under treatment during all seasons, but acute cases from swimming and diving, occur during the spring and summer months, chiefly in boys from eight to sixteen years of age; a much smaller number occurring in the fall and winter. If the acute form be promptly treated, entire recovery takes place; but should the case not be seen until after the chill, it is always followed by a discharge of shorter or longer duration.

The following is a summary of the aural diseases and complications of existing diseases for which patients applied for treatment:*

Acute purulent otitis media; chronic purulent otitis media (from repeated exposure in bathing); acute catarrhal otitis media; subacute catarrhal otitis media; acute exacerbation of existing chronic purulent otitis media; otitis externa diffusa; otitis externa circumscripta; otitis externa exudativa; myringitis (either independently or in connection with inflammation of the external auditory canal); impaction of cerumen; otalgia due to exposure, etc.; aggravation of symptoms arising from chronic catarrhal inflammation by abuse of sea bathing (bathing frequently and remaining in the water too long).

In cases not recognized, the symptoms of violent headache, furious delirium and coma, give the physician the impression that disease of the brain is present, and the cases thus improperly treated sometimes terminate in death. The morbid condition in the first stage consists in acute inflammation of the extremely delicate mucous membrane lining the middle ear. The inflammation is followed by effusion of fluid, and after twenty-four hours by the formation of pus. It is in every instance attended by fever, with swelling and inflammation of the naso-pharyngeal space and great pain. If this fluid or pus be removed by incision into the membrana tympani, followed by the use of the air douche and injections of hot antiseptic wash, the patient recovers and the ear is saved. The patient is apt to remain deaf for several weeks, and the use of Politzer's air douche is necessary to keep the Eustachian tube open; the local application of tincture of iodine brushed over the mastoid facilitates the removal of the inflammatory thickening. To diminish the discharge of pus, should it continue, we may employ a powder of boric acid, blown into the meatus before it is washed out,

* Sexton—"The Ear and its Diseases."

and reapplied twice a day until the discharge shall have ceased and the perforation become closed.

In Australia and India, where they have a very hot climate and most of the towns are on the sea coast, the people bathe very frequently, some even three times daily, from June to October. During these months it has been noticed (Dr. Kenny) that the number of patients suffering from ear troubles has been considerably augmented. They bathe in large enclosures for fear of the sharks, and these baths have a depth of water from twelve to sixteen feet. At these great depths the bathers are constantly diving, and added to the irritation of saline water in the auditory meatus, there is also the great increase of pressure to which the membrana tympani is subjected.

Dr. Macnaughton Jones has noticed the occurrence of exostosis within the meatus to persons very fond of sea bathing. The ears, when tender or diseased, in ladies should be protected in bathing by an oil silk cap, while gentlemen should place a piece of wool in the ear, or some form of protection which can be removed as soon as the bathing is over.

*Russian and Turkish Baths.*—Acute inflammation of the middle ear, etc., is liable sometimes to occur after the use of these baths, which render the patient extremely susceptible to cold and consequent catarrh of the upper air-passages.

Sexton reports four cases of aural disease resulting from long continued indulgence in the Turkish bath. Two of these patients had chronic purulent otitis media, and one chronic catarrh of the middle ear, while one patient was suffering from acute inflammation of the auditory canal.

Six cases of acute purulent inflammation of the middle ear, resulting from the effects of getting water in the ears or from the susceptibility induced by baths of various kinds, were recorded: A shower bath in 1 case; hot water baths in 2 cases; hydrant water falling in the ear in 1 case; exposure after ordinary bath in 1 case; bathing when overheated in 1 case.

One patient, a male 40 years of age, who was suffering from chronic catarrh of the middle ear, attributed a marked increase of tinnitus aurium to taking a cold bath.

## THE INJURIOUS INFLUENCE OF WATER INTRODUCED INTO THE EAR BY THE NASAL DOUCHE OR SNUFFING UP COLD WATER.

We have explained the injury which results from the introduction of water into the auditory canal, also the serious disturbance produced by the same when passing into the Eustachian tube by very sudden efforts at swallowing, now the same results will follow the improper use of what is known as the nasal douche or in snuffing up cold water or solutions of medicinal substances. The first great point is to remember that the fluids should not be cold; the second, is that the head should be kept level and not thrown very far back; third, individuals using this method of cleansing the throat and back of the nose should not expose themselves to the open air for some time after using either of these methods. It is much better to use the steam or spray form of apparatus as less risk to the ears, and the result in a medical view will be as good, if not better, as cleansing agents.

The same results will occur from the post nasal syringe when improperly employed.

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## COLD WATER TO THE SCALP AS A CAUSE OF EAR DISEASE.

The present fashion in young boys and even men in cutting the hair close to the scalp, both in summer and winter, is a cause of disease of the ear. It is a well-recognized fact that we hear with the skin of the scalp and the bones of the head, and irritation by dampening the skin impairs the hearing, and when cold water is applied too freely it will produce coryza and earache. Again, young girls saturate their hair in bathing and then allow the air to dry it. Bathing caps should be always used under such circumstances. The hair is a great protection from cold, and during the winter should be used to protect the scalp and throat. The new form of clipper by which the hair is cropped very close is a cause of earache, likely to follow inflammation of the middle ear, especially if the person is afterward placed in a car or carriage or cab, and the wind allowed full play on the part.

# COMMUNICATIONS.

## APPENDICITIS FROM A MEDICAL STANDPOINT.

T. L. McDERMOTT, M.D., Louisville, Ky.

The unfinished report of Dr. Cartledge on the classification of appendicitis, which was interrupted at our last meeting, and the exhibition of specimens of some late operations, suggested some comments on the subject from a medical standpoint. It was, therefore, made the special order for this meeting, and as I feel no more important question is agitating the public expectancy both here and abroad than this, I invoke by this method the local sentiment favorable or otherwise as to its advisability, and the character of cases deserving its application.

In this, as in many other of those heroic operations that enkindle the enthusiasm of the original promoters, and startle the laity with the wonders of science that thrills even the initiated, snatching from death the innocent victim, and restoring to health the misanthropic cripple, it certainly seems inexpedient for the unsurgical brother to dampen the ardor or quench the fire that illumes such desolate pathways. But, on the other hand, as license runs wild with its sensuous victories, and culprits stalk where angels fear to tread, the history of all these grand successes is blotted frequently by unrestrained excesses and the brilliant progress of the art destroyed by the unwary and the charlatan; and it does become at times the duty of the peaceful practitioner, standing apart as it were from the conflict between the knife and dissolution, to stay the hand grown riotous by acclamations.

Not that I expect to say anything new on the subject, worn threadbare possibly already, but simply to bring to a more vivid experience its faults and triumphs, as demonstrated at home. The unalterable fact obtains, however, that a sentiment is fast gaining assertion amongst the medical members of the brotherhood, who formerly after diagnosis relinquished without question their subjects to the knife, and contrawise amongst many of the adroit surgeons themselves there is already a disposition to eliminate many of their former operable cases.

Only a few years ago it became an open boast that laparotomy was, in skillful hands, a decidedly safe operation, so entirely harmless that it took rank among exploratory procedures, and it was growing as common to cut open the belly to elicit or confirm a diagnosis as to perform many of the minor operations; so much so that in many instances life was sacrificed in the useless search for supposed disease in healthy organs. Nor do I wish to affirm here that the quest was uncalled for, nor to blight the fame achieved in some of those undertakings, but I *do* assume that in many instances the gravest concern must follow imprudent proceedings.

The most serious obstacle to the fullest enlightenment naturally occurs from that want of frankness in the ranks of the profession itself, which interposes an almost insuperable barrier to a quick and decided solution of its utility; and for many reasons, but primarily because the experimentation which naturally opens so many new fields of conquest in surgical enterprise, only proves their availibility by continuous research, and they traverse many tortuous courses before the danger signal calls a halt. Secondarily, I presume the implied acquiescense to doubtful results, and the frequently unquestioned exhibition of specimens that do not fully bear out the alarming aspect the operator would have us affirm.

I have no doubt that many lacerated appendices could trace their origin to the inevitable rudeness that attended their separation, and seem to give credence to an urgency that calmer retrospection would deny. Of course the gravity of the responsibility where fatal results attend these operations, militates strongly toward the defense of measures attended by such fateful consequences, and whether the operation were wise or incompetent, a fellow feeling for the author would bias an untoward criticism of his work.

As I intend this introduction to the discussion of the evening as a prelude ot more statistical facts in its elaboration, I

shall not enter fully into the etiology (which is somewhat obscure), nor to the technique (which belongs properly to the surgeon), nor the diagnosis (which is the property of both), nor the pathology (which is the rock that divides the limpid stream of life, and the election of either channel after its passage, whether it be medical or surgical, decides in a large degree the fate of the eventful voyage). Of course the supreme comprehension of them all merges into the general field of treatment, when the battle-gauge is given and upon which depends the weal or woe of the subject.

To those painstaking, erudite, thoughtful, conscientious surgeons who bring to their task, in these monumental trials, the unimpeachable strength of purpose that wavers before no disaster, nor incriminates their courage, be the results what they may, always remembering a human life is in the balance and at the mercy of their prowess, I wish to bow in humble gratitude and sublime devoir. If there is any lofty pinnacle to which ambition towers and upon whose crest reposes its godliest hero, I believe the crown is theirs. In silent chamber and with bated breath the hovering circle waits his wondrous coming, and the canticle of joy or the deep-toned requiem, his departure.

Is it wonderful, then, that we should pause in contemplating the risks and adventures that environ every step, or stop in this debatable territory? In this connection it is interesting to note that Talamon of Paris, Guttman of Berlin, and Treves of London, affirm that from 85 to 90 per cent. of patients suffering from appendicitis recover spontaneously without the use of the knife, and Maurin and Hektoen through many hundred autopsies demonstrate the fact that from 16 to 30 per cent. of peri-appendicular adhesions, some even where perforation itself had occurred, were found with no antecedent history that tokened their existence. With this fact staring us in the face it becomes a moot question, whether the late day recognition that appendicitis is the cause of 95 per cent. of diseases invading this territory, mostly in the hands of some, demanding operation for relief, has been a blessing or a curse to humanity.

As regards its etiology, much commendation can be taken from the assurance that fæces, calcium salts, etc., are the concretions met with, rarely seeds or foreign bodies, so that we can return with renewed enjoyment to the small fruits of early life when we devoured baskets full without consequences.

The diagnosis, coupled with its subsequent prognosis, is, I take it, the foundation stone of the whole fabric, mysterious as it must be in an affection which may be acute or chronic, continuous or relapsing, with great variation of often indefinite symptoms comparable to typhoid, peritonitis, strangulation, typhilitis and others. Pain, the most prominent of all, is frequently referable to other regions, though in males (and I have not seen it mentioned) it is mostly located in the testes, and is of great intensity. It may be absent, although the most prominent symptom. The temperature is vexing; tympanites and vomiting are variable in their appearance and conflicting; acute indigestion and nephritic colic are most confounding; the pelvic derangements lend no small assistance to the general confusion; to the practiced eye the semi-shock in the acute, and the peculiar malaise in the chronic cases, accentuate its intuition.

As I said before, the condition of the viscera and appendix furnish food for controversy, even after removal.

As regards treatment, whether it shall be medical or surgical, brings the issue for yourselves to decide.

There is no question that the literature of this subject has changed rapidly during the past few years to more conservatism in the use of the knife, and personally and from individual experience I have not found the relief from appendisectomy that is claimed or I had expected. Without citation of individual cases, the results have been far from gratifying, nor do I believe the death rate as light as reports would make us believe.

I present here an extract from one of the daily journals of last week, which probably escaped the notice of even the majority of the profession, bearing mute but inglorious witness to the prevalence of its abuse:

"VICTIM OF EXPERIMENT.

Death of Norman Munro, the New York publisher. Submitted to an operation for appendicitis when it was unnecessary.

"NEW YORK, February 24.

"Norman Munro, the yachtsman and publisher, died at 6.15 o'clock to-night, at the Hoffman House. The cause of death was heart failure.

"Mr. Munro had undergone an operation for appendicitis, but it was afterward found that the patient was not suffering from the disease, and that the operation was not necessary.

"Henry, Mr. Munro's eleven-year-old son, who attended a private school at Dobbs' Ferry, had his vermiform appendix removed by Dr. Abbee on Sunday last. The boy had complained of a pain in his right side immediately after coasting. He is convalescent now.

"HAD THE SYMPTOMS.

"Mr. Munro complained of a soreness in the right side early in the week, and suspected that he had appendicitis. Under ordinary circumstances, he would not have given the matter much thought, but his symptoms being similar to those of his son led him to believe that he was suffering from the same disease. Mr. Munro became interested in the subject of appendicitis, and decided to have the appendix removed. The patient was put under the influence of ether on Friday and the operation was performed.

"No foreign substance was found in the appendix of the parent or in that of the son. There was *only a gangrenous inflammation of the appendix.** Mr. Munro recovered from the effects of the ether and conversed with his physicians half an hour after the operation.

"He seemed confident that he would pull through just as his son had done. During the night and early morning his condition grew rapidly worse. At two o'clock in the afternoon Dr. Abbe said the end was looked for any moment. His family was present when he died."

A "Victim of Experiment" was the flashing headline in large type that chronicled the catastrophe, although the operation, it appears, was performed by Dr. Abbe, one of the leading men in our ranks.

The discussion of this interesting subject cannot fail of the most salutary effect at all events, and for the sake of that great medical enlightenment that is making our age more brilliant and progressive than any of its predecessors, I hope it will continue until the veil is lifted from its present obscurity, and the refulgence of its promise becomes brighter for the ordeal it has endured.

## A CASE OF MULTIPLE NEURITIS (ALCOHOLIC).

HERMAN D. MARCUS, M. D.,* PHILADELPHIA.

The following case is interesting, owing to the markedly low temperature and its duration for 132 hours.

L. N., female, aged 34 years, was brought to the Philadelphia Hospital on December 31, 1892, in an entirely helpless condition. Her condition was as follows:

*Mental State:* Somewhat variable, seems at times rational, again wandering, mistaking those around her for former friends. Occasionally a mild muttering, delirium and hallucinations. At times believes herself at home, not recognizing her surroundings, although she has been in hospitals before.

*Motor Condition:* Complete paralysis of both legs, with the exception of being able to move left thigh from pelvis, flexing it slightly. Limbs remain in whatever position placed. No foot-drop. Great toe slightly depressed, other toes slightly curved. Has marked double hand-drop; also partial paralysis above elbow, but is able to partially elevate the arms. No facial or ocular paralysis.

*Sensory Condition:* Lower extremities are everywhere anæsthetic, showing difference in degree, mostly marked below the knees and decreasing on ascending, continuing to ensiform cartilage. Partial anæsthesia of upper extremities, decreasing from distal to proximal ends. Retardation of sensory condition in areas of anæsthesia. Handling of nerve trunks in lower extremities causes severe pain. Squeezing of feet, moving limbs and compressing muscles, or very deep pressure

* Italics are ours. Comment is unnecessary.—ED.

* Late Resident Physician at the Philadelphia Hospital.

causes severe pain. Patient is in constant fear of being touched. The hyperæsthesia on deep pressure is also imminent in upper extremities.

*Vaso-motor and Trophic Condition:* Dark, softened areas on heels. On buttocks and in lumbar region skin shows some change, and in one place the skin is broken, resembling a bed-sore. Left knee is apparently increased in size, an apparently acute atrophy. Has involuntary evacuations of bowels and yellowish green vaginal discharge.

*Treatment*: Following treatment was prescribed by Dr. Mills, the visiting physician: Bathe lower limbs once daily, for 10 minutes with hot water (115°), followed by inunction in legs of

℞ Atropine sulph..... gr. 1-6
Ung. hydrarg..... ʒv.
Lanolin..... ʒiii.
M. Use ʒ¼ twice daily.

℞ Tr. nucis vom..... mv.
Tr. digitalis..... mx.
Every 4 hours.

℞ Sodii salicyl..... gr. x.
Sodii iodid..... gr. v.
Sodii boom..... gr. v.
Aquæ..... fʒi.
Every 4 hours.

Wash eyes with Boracic acid.

Vaginal douche (bichloride mercury 1-5000) once daily followed by hot water; sand bags to arms and legs.

Two days after admission, January 21, 1883, following was noted. Almost constant delirium—mind not as clear to-day as on 31st ult. Rambles almost continually, but by a strong effort her attention can be held and she can be made to respond sensibly to some questions. Complains of pain when her limbs are moved. Anæsthesia of legs continue, paralysis of legs unchanged. Paralysis of upper extremities increased somewhat, having now no control over movements of upper arm. Her feet tend to fall into crucial position, probably due to a paralysis which is merely below knees and less marked above. Her tongue is dry and brown. No urine passed from this morning until 2 P. M. Treatment continued and ordered catheterized every four hours.

January 3d. Pulse between 115 and 120, weak and compressible; temperature about 99°; respiration shallow and hurried (about 30); still incoherent, but her mind is clearing up. On examination paralysis of extremities has increased since yesterday, so that now she is barely able to make a slight movement of elevation or adduction. Some slight increase in sensibility in both arms; knee and muscle jerks abolished.

From this on her condition became variable, at times rallying then again relapsing into her former state.

Strychina sulph. gr. $\frac{1}{30}$, was prescribed three times daily on the 9th, and to this was added whiskey ʒiii, milk fʒiii every half hour, in divided doses. The sodium mixture was discontinued. On the 12th, her temperature became subnormal, 96.6°, and from then on sank gradually until the 16th, it reached 91.2° at 7 P. M., rising to 92° at 11 P. M., and remaining at this point until her death on the 17th, at 8.30 A. M.

The temperature was taken both in the mouth and rectum, with a Hick's thermometer. This thermometer was afterwards tested and was found positively correct.

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**The Awakening Effect of Cocaine.**

A few days ago a patient who had toothache, wishing to stop it immediately, secured nine grains of cocaine in solution, and took it into his mouth a little at a time, holding it until the accumulation of saliva become so abundant that he had to spit it out. He began using the cocaine in this manner at 5 P. M., and did not cease till 10.22 P. M., same evening. As it was then bedtime, he thought he would make sleep certain by taking 20 grains of chloral. Immediately after taking the latter drug, he took into his mouth some more cocaine and went to bed. He "swashed" the cocaine solution about in his mouth a while, then spat it out, turned on his side, and tried to go to sleep. Sleep, however, did not come; on the contrary, he did not even become drowsy. Having lain awake till midnight, and not feeling sleepy at that hour, he took, as nearly as he could tell, about *one teaspoonful* of laudanum. He went to bed again, and remained awake till three o'clock. Sleep lasted only four hours. Following this was headache.

I have often had my attention called to the fact that cocaine will keep patients awake at night when the drug is administered late in the day, but I did not know that 20 grains of chloral and a teaspoonful of laudanum would not overcome "cocaine wakefulness."—*Medical Record.*

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### A PILL FOR ANÆMIA.

Prof. Edlefsen (*La Semaine Médicale*, No. 24, 1894) recommends the following pill in anæmia:

℞ Iron reduced by Hydrogen,.....
Powdered Camphor,.....āā 6 | 0 (ʒjss).
Extr. Gentian,.....5 | 0 (ʒji 1-4).
Mucilage Gum Arabic.....q. s.

Sufficient for ninety pills. Two to three pills three times a day.

He has found this formula of value both in anæmia and in chlorosis, especially when they are accompanied by cardiac disturbances as weakness and irregularity of the pulse.

### ECHINOCOCCUS CYSTS.

Prof. Bacelli (*Medicinische Nenigkeiten*, No. 15, 1894) treats echinococcus cysts by injection of a solution of sublimate. If the parasite is situated in the liver he punctures with a well sterilized trocar of a diameter of two and a half mms. the cyst at its highest point, and withdraws a moderate quantity of the fluid, following this with an injection of about twenty grams of a 1-per-cent. solution of sublimate. The tube is withdrawn and an antiseptic bandage applied. In five days the dressing is removed. The parasite is then destroyed and the subjective and objective symptoms gradually retrogress.

### SENECIO IN FUNCTIONAL AMENORRHŒA.

Dr. Murrel (*Hospitals-Tidende* No. 15, 1894) has experimented with senecio as a remedy in functional amenorrhœa on account of its being employed in England as a domestic remedy in this affection and with good results. He used a 10-per-cent. tincture of this plant in doses of an ounce four times a day. In amenorrhœa, due to general anæmia, it was inactive.

### MIGRAINE.

Dr. Freudenberg (*La Semaine Medicale*, No. 16, 1894) advises the use of the following formula in migraine:

℞ Mur. Morphine,.....0 | 01 (gr. 1-6).
Salicylate Soda,.....0 | 25 (gr. iv).
Phenacetine,.....0 | 25 (gr. iv).

Sufficient for one powder. One or two according to circumstances.

Dr. Tchetius (*ibid.*) recommends the following:

℞ Saccharine,.....0 | 01 (gr. 1-6)
Mur. Quinine,.....0 | 05 (gr. j).
Salicylate Soda.....0 | 15 (gr. ijss).
Phenacetine,.....3 | 0 (gr. xlv).

Sufficient for ten capsules. One at a dose.

### ECZEMA IN CHILDREN.

Dr. Marfan (*Hospitals-Tidende*, No. 15, 1894) distinguishes two forms of eczema in children: a seborrhœic, and a dry and patchy form. In the seborrhœic variety, in fat children, he reduces the amount of food and administers calomel, or removes the crusts and applies the following salve:

℞ Precipitated Sulphur,..... 1 | 0 (grs. xv).
Oxide Zinc..... 4 | 0 (ʒj).
Lanoline,.....
Vaseline,.....15 | 0 (ʒiv).

In the other form he applies locally:

℞ Salicylic Acid..... 0 | 05-.10 (grs. j-jss).
Starch,
Oxide Zinc.....āā 40 | (ʒ j).
Lanoline,
Vaseline.....āā 15 | 0 (ʒ jv).

### EARACHE.

In the (*Progrès Médical*, No. 16, 1894) the following is praised in earache of inflammatory origin:

℞ Powdered Menthol..... 1 | 25 (grs. xix).
Camphor..... 1 | 25 (grs. xix).
Vaseline..... 24 | 0 (ʒ vj).

Introduce a little into the ear several times a day.

### A CASE OF SORE THROAT FROM COPAIVA.

Dr. Mendel (*Le Bulletin Médical*, No. 24, 1894) had under observation a young man of twenty-two years, who, for gonorrhœa, took for several days nine capsules of copaiva a day, and then broke out with a pronounced erythematous copaiva exanthem of the ordinary appearance, and with the following throat symptoms: the soft palate, uvula, tonsils and the anterior portion of the faucial arch were very red and œdematous. The œdema of the uvula was so great that it was increased to double its

*In charge of the Translator, F. H. Pritchard, A. M., M.D.

size. The whole of the hyperemic portion was covered with numerous miliary, deep-red and vesicular prominences. This state persisted for three days, when it disappeared with the erythema.

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FALLING OF THE HAIR AND RINGWORM.

Dr. Brocq (*Progrès Medical*, No. 16, 1894) recommends the following, both in falling of the hair and ringworm:

℞ Carbolic Acid,
Chloral,
Tinct. Iodine.....āā 100 | 0 (℥iij ℥j).

Apply once a week with a brush. Three to four times for ringworm.

---

CHOLERIFORM DIARRHŒA IN CHILDREN.

Dr. Braithwaite (*La Semaine Medicale*, No. 24, 1894) has had good results in choleriform diarrhœa in children with the following:

℞ Salicylate Soda
Sulphate Iron.....āā 0 | 60 (grs. lx ).
Neutral Pure Glycerine.. 10 | 0 (℥ ijss).
Water..... 40 | 0 (℥ jss).

A teaspoonful four times a day.

---

LOCAL ANÆSTHESIA IN EXTRACTION OF TEETH.

Dr. C. Karacatsanis (*La Semaine Medicale*, No. 24, 1894) extracts teeth without pain by first applying a strong solution of tufts of absorbent cotton to each side of the tooth, and as soon as anæsthesia is complete, the gum is separated from the tooth by means of a bistoury, and fresh pledgets of cotton are again placed into these cavities. The patient should be cautioned not to swallow his saliva, as it is more or less saturated with cocaine. Then a little of the following mixture is sprayed onto the gum:

℞ Chloroform .....25 | 0 (℥vj).
Ether .....40 | 0 (℥j ¼).
Menthol..... 3 | 0 (grs. xlv).
Mur. Cocaine .....
Essence Peppermint .....āā.. 1 | 0 (grs. xv).

The tooth is then extracted. There will be no pain with all forms of toothache, except with alveolo-dental periostitis, it is where it is impossible to subdue the pain entirely.

(This procedure would seem rather bothersome and slow. I employ a hypodermic syringe, and inject at the base of each root of the tooth to be pulled, a few drops of a 2-4 per cent. solution of cocaine with strong carbolic acid added, massage the gum for a minute on each side, and after cutting around the root, extract. In order to avoid pain the solution must be deeply injected around each root until the gum turns white. There is some danger of dangerous effects from the cocaine in such vascular tissues as the gums even with a 1-2 per cent. solution; excitement, slight delirium, paleness, faintness, coldness of the hands and feet and nervous twitchings, or even chilly sensations. I have had as many cases of untoward effects from weak as with stronger solutions. Carbolic acid acts as a preservative for the solution, and aids the action of the cocaine as has been noticed by various observers, as Gluck, Vau, etc. Atropine has been proposed as an efficient antidote to be added to the solution, but I have found it of very little or no service. The best antidotes are those vaso-dilators and cardiac stimulants as which act rapidly as nitro-glycerine and amyl nitrite. With the latter I have had no experience, but the former I can heartily recommend as worthy of confidence. I have employed it both with the solution to be injected and apart. It acts satisfactorily and at once, but only little is to be added to the injected solution, or it will spoil the action of the cocaine, much of which influence as an anæsthetic is due to its vaso-constrictive properties. I employ now a five-per-cent. solution of the cocaine, add to this watery preparation, eight drops of strong carbolic acid and five drops of a one-per-cent. solution of nitro-glycerine. I never have observed any disagreeable effects from the use of this, though without the nitro-glycerine the same preparation will give rise to trouble. Cocaine is always to be employed with caution and respected decidedly, for no one knows when it will act diasagreeably).—*Trans.*

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**Ichthyol.**

This drug is proving itself to be one of the most valuable in the materia medica. An ointment consisting of twenty-five per cent. of ichthyol and seventy-five per cent. of lanolin, is the very best remedy for erysipelas. Ichthyol is also useful in rheumatism, in the form of an ointment consisting of equal parts of lanolin and ichthyol.—*Modern Medicine.*

# BACTERIOLOGICAL NOTES.

## THE ACTION OF LIGHT UPON THE DIPHTHERIA BACILLUS.

Ledoux-Lebard (*Archives de Med. Experimentale*) gives the results of his experiments to determine whether the influence of diffused light is destructive to germs as well as the direct rays of the sun. The conclusions reached are as follows:

1. The action of diffused light does not prevent the development of cultures of the diphtheria germs. The direct rays of the sun arrests the development of the germs. Diffused light has no bactericide power on bacteria in neutralized bouillon, but it has a marked bactericide power on the diphtheria bacilli in distilled water.

2. Diffused light kills dry cultures of diphtheria spread in thin layers in less than two days (24 hours' exposure to the light.)

3. The direct rays of sun light acts in the same manner as the diffused rays, but with greater rapidity.

4. The bactericide power of light in relation to the diphtheria bacillus is due very largely to the most highly refracted rays of the spectrum. The less refracted rays of the spectrum have little or no effect.

5. Light by virtue of its bactericide power, sterilized in less than two days the diphtheria bacilli either moist or dry, and hence is a prophylactic agent against diphtheria.

6. In diphtheritic membranes exposed to the light, many of the bacilli are reached only by the light after it has lost part of its intensity, and hence the bacteria retain their vitality and virulence much longer.

8. Light may be utilized in the disinfection of places contaminated by diphtheria.

[The results here reported are of considerable interest when the persistent nature of diphtheria is considered. There are well authenticated cases, where the disease has been contracted from rooms or clothing used by diphtheria patients, years after the disease. It has been noticed that in these cases the infected article has been kept away from the light, and if a room, it has been kept darkened. About two years ago, Dr. Sternberg brought out anew the importance of sunlight in disinfecting against Asiatic cholera. It is also well known that other bacteria are exceedingly susceptible to the influence of sunlight. These facts should be carefully considered by all physicians and the use of sunlight freely indulged in. It seems to be effective and its more extended use may render it a much more valuable prophylactic agent than it now is.—ED.]

## AN EPIDEMIC OF TYPHOID FEVER CAUSED BY MILK.

In the *Zeitschrift fur Fleisch und Milchhygiene*, Jan., 1894, there is an interesting account of an epidemic of typhoid fever in which the source of infection is very clearly shown to have been in the milk supply. An epidemic of this disease broke out in the two prisons of Strasburg in 1880, after twenty years of freedom from the disease. All of the inmates attacked had consumed milk from a particular locality. Of those who had used this milk once or more, 17 per cent. were attacked with typhoid; while out of the three hundred other persons who did not use the milk not one was attacked with the disease. The milk was used in an unsterilized condition, and when its use was stopped the epidemic came to an end.

[The continued and constantly increasing number of epidemics of typhoid fever traceable to the milk supply as the channel of infection, is a signal for more rigid inspection of dairies furnishing milk to cities and communities. The danger, as is well known, is largely confined to the contamination of the milk with water containing typhoid bacteria. This fact renders it of great importance that the sanitary conditions surrounding the dairy should be carefully inquired into, and in all cases where there is a possible chance of the water used in rinsing the milk pans,

pails, etc., being contaminated with the dejecta from typhoid patients, the milk should not be used, excepting the most careful methods of sterilization are employed. Milk is one of the best media for the multiplication of typhoid bacteria, and the fact that these bacteria produce no visible change in the milk by which their presence can be detected renders it a most favorable channel for these bacteria to gain entrance to the system. Too much care cannot be exercised to keep milk from becoming contaminated with these bacteria.—ED.]

## THE RELATION OF THE BACILLUS OF TUBERCULOSIS IN FOWLS TO THE ONE OF TUBERCULOSIS OF MAN AND OTHER MAMMALS.

Mafucci (*Zeitschrift f. Hygiene*, 1892) has studied the tuberculosis of fowls, and arrives at the following conclusions in reference to its bacillus:

1. It does not produce tuberculosis in guinea-pigs, and seldom produces general tuberculosis in rabbits.

2. On the various culture media it grows with an appearance different from that of the bacillus of mammalian tuberculosis.

3. It grows at temperatures between 35° C. and 45° C., and it is destroyed at 70° C.

4. In cultures at 45° and 50° C., the bacillus grows in long, thick, branched forms.

5. The bacillus retains, even after two years, its vegetative and pathogenic powers.

6. The destruction of the bacilli produces a substance which is poisonous for guinea-pigs and less so for adult fowls.

7. The tubercle excited by the growth of the bacillus in fowls is destitute of giant cells.

The bacillus of mammalian tuberculosis differs from that of avian tuberculosis according to Mafucci, in the following respects:

1. It produces tuberculosis in guinea-pigs and rabbits, but not in fowls.

2. Its cultures differ in appearance from those of the avian bacillus.

3. It grows at a temperature between 30° and 40° C.

4. It is destroyed at a temperature of 65° C. for one hour.

5. At temperatures between 43° and 45° C., it does not change its form in the cultures.

6. At 45° C. it loses its vegetative power in a few days.

7. The old moist cultures, after a year, are with difficulty induced to grow on fresh culture media or in the animal body.

8. The destruction of the bacilli gives rise to a substance that is poisonous for guinea-pigs, and often also for adult fowls.

9. The mammalian tubercle generally possesses giant cells.

On these grounds Mafucci holds that the bacilli of these forms of tuberculosis belong to two varieties, but he is not sure of specific differences. He is not decided as to whether man can take tuberculosis from fowls.

[It is of interest to add that the thermal death-point of the tubercle bacillus is much lower than that given by the author. —ED.]

### For Ringworm.

Iodine has been found to be one of the most effective agents for destroying the parasite upon which this disease depends. An excellent method of applying it is the following: Thoroughly cleanse the scalp with soap and water. Dry perfectly, then apply a solution of one part of pure iodine in thirty parts of flexible collodion. Renew the application each day for four days. At the end of fifteen days, remove the collodion, wash the scalp first with soap and water, then, after thoroughly removing the soap, wash with a hot solution of bichloride of mercury, 1-2500. After allowing the bichloride solution to remain in contact with the scalp for half an hour, wash with pure water, dry, and apply vaseline or zinc ointment. If necessary, repeat the application.—*Modern Medicine.*

# THE MEDICAL AND SURGICAL REPORTER

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SATURDAY, JUNE 9, 1894.

## EDITORIAL.

### STYLE IN MEDICAL WRITING.

The responsibility of the editor of a medical journal is very great. It is his duty to promote the diffusion of medical knowledge, not only by his own writing, but by seeking from contributors articles that will be useful to this end, and by selecting from contemporary publications the most valuable papers, of which usually only abstracts are presented. The medical journal is a most important means of professional aid and education. It ought to help the practitioner in his daily work, and it ought to enlarge the sphere of his knowledge, and stimulate him to active thought.

But whatever information, advice and instruction are given, the manner of their presentation is of great importance. "The style is the man," it has been said, and certainly the style of a medical contribution has much to do with its ready reception. Dr. Samuel Johnson, in his memoir of the illustrious Boerhaave, wrote: "Nor was he unacquainted with the art of recommending truth by elegance, and embellishing the philosopher with polite literature; he knew but a small part of mankind will sacrifice their pleasure to their improvement, and those authors who would find many readers, must endeavor to please while they instruct." Accepting this statement from a great essayist in regard to a great physician—a physician so famous in his day that a letter sent to him from India, having on it only his name and Europe, came into his hand with reasonable promptness—we trust that a brief consideration of style in medical writing may not be unacceptable, and may prove of some value.

When the physician purposes writing a paper, let him, so far as possible, understand his subject, be reasonably certain that what he writes will be useful to the profession, and let him select a proper title for his essay. Probably there are more frequent mistakes in the last matter than in any other, causing no end of worry and trouble to those who are studying a subject, or who are preparing an

index of medical literature. Every child has a right to his own name, and so the medical contribution ought to have a distinctive title. To call the paper "A Remarkable Case," or an "Extraordinary Case," is almost meaningless, and quite mischievous. A similar criticism may be made of many other designations—designations that do not designate—applied to articles too often found in medical journals. Let the title be not only distinctive, but also brief. Then let the story be told in simple language, told as briefly as possible; "boil down," provided clearness and completeness are not sacrificed in condensation.

Of course the ordinary rules of syntax will be observed, and verbs and nouns will not be allowed to indulge in promiscuous intercourse. This may seem an unneeded direction, but it is often unheeded, for violations of it are not uncommon even in well-known writers.

Let strength be first sought rather than beauty. Richness of ornament and wealth of illustration must not be suffered to obscure thought or lead the reader away from the essential points; if these assist, make clearer and more attractive, and if spontaneous and incidental, like the rainbow that arches the waterfall telling the force of the rushing waters, very well. But let the writer never get on stilts and attempt to lift his head into the clouds. The subject and the style should correspond, and, as Voltaire has said, there is nothing more rare and difficult than to make this correspondence.

In a further consideration of the subject, we will speak more fully and plainly of the errors of composition as observed in professional writings, and of the means by which a good medical style may be be acquired.

## LECKY AND GRANT ALLEN ON PROSTITUTION.

Those who have read Lecky's "History of Morals in Europe" will recall his eloquent language in regard to the prostitute and prostitution, and his quasi-defence of this accursed form of social impurity.

This is the defence: In referring to the prostitute, he says: "Herself the supreme type of vice, she is ultimately the most efficient guardian of virtue. But for her, the unchallenged purity of countless happy homes would be polluted, and not a few who, in the pride of their untempted chastity, think of her with an indignant shudder, would have known the agony of remorse and despair."

Grant Allen, a name so well known in science and literature, in a little volume of poems recently published, entitled "*The Lower Slopes*," has one called "*Sunday-Night at Mabille*," terrible and pathetic in its picture of the suffering and sacrifice of these miserable victims of man's lust. The poem concludes with a question that probably may set those who are content to say that prostitution is a necessary evil, and that it protects the purity of countless happy homes to thinking at least:

> "One question ever rises to my lips,
> One question that I scarcely dare to breathe:—
> If woman's virtue cost so much to keep,
> Good friend, is woman's virtue worth the price?"

### Antiseptic Snuff-Powder.

The following is a combination employed by Dr. Leonard A. Dessar:—

℞

| | |
|---|---|
| Menthol | 10.0 |
| Tannic acid | 2.0 |
| Boracic acid | 30.0 |
| Bismuth subnitrate | 20.0 |
| Starch | 50.0 |
| Cocaine | |
| Aristol | āā 0.5 |

Sig.: Make a fine powder.—*International Journal of Surgery.*

YOUNG DOCTOR:—Just think! Six of my patients recovered this week.

OLD DOCTOR:—It's all your own fault, my boy; you spend too much time at the club.—*Life.*

# ABSTRACTS.

## URTICARIA: ITS NATURE AND TREATMENT.

By Dr. Stephen Mackenzie (*British Journal of Dermatology*. March, 1894).—As here pointed out, all the phenomena concerned in the development of an attack of urticaria can be easily followed out in cases of "factitious" urticaria, and in this way: A scratch at once brings out a white streak, due to contraction of the irritated cutaneous vessels, from stimulation probably of vaso-constrictor nerves; then we have a line of redness, wider than the original white streak, caused by vascular dilatation, quasi-paralytic in character; dilatation is succeeded by stasis, transudation of serous and corpuscular elements, this constituting the "wheal." There is usually but little diapedesis of colored corpuscles, hence the white or pink color of the wheal; but this may be more marked, or rupture may occur, hence *urticaria hæmorrhagica;* or the transudation may raise the stratum lucidum and stratum corneum of the epidermis, hence *urticaria bullosa*. The whole process is reflex, so that we must have efferent nerve fibres and a centre, the latter being probably constituted by "the dense plexus of fine nerve fibres in the superficial layer of the corium." This seems to be the mode of action of *direct* irritants; but what of *urticaria ab ingestis?* Dr. Mackenzie, while admitting that it may be a *central* reflex phenomenon starting from an irritation of the gastric mucous membrane, thinks it more probable that "*something* is absorbed which circulates in the blood, and reaches the nervous plexus in the skin," a view which the author finds supported by the facts that factitious urticaria is most easily provoked in cases in which the original cause of the disease is indirect, connected with some error of diet or some idiosyncracy, and that urticaria is nearly always more or less widely and indiscriminately distributed over the cutaneous surface, and not in the territory of any definite nervous supply—entirely unlike the distribution of zoster.

The mucous membranes are sometimes affected in urticaria; that of the mouth may be seen to be swollen; there may be asthma or dyspnœa, from urticarial swelling in larynx or bronchioles; or hæmatemesis from an urticarial condition of the gastric mucosa. On the skin, also, the urticarial papule may pass into an inflammatory papule, when we have the so-called *lichen urticatus*.

Dr. Mackenzie refers to some of the less common causes of urticaria, particularly to the association of the disease with hydatids; it sometimes follows pregnancy; in one case it occurred fifteen times in succession after the passing of a uterine sound; it may occur during menstruation or pregnancy, or from simple emotion.

After giving some details of a few very unusual cases, the author passes on to discuss treatment under two heads—removal of cause, and mitigation of effects. Local irritations must be removed—animal parasites, irritating clothing, unusual articles of diet. In acute cases very mild measures suffice—a simple and bland diet, a stomachic, and a warm bath. In more obstinate cases the skin must be soothed by a nightly warm bath (for fifteen minutes) containing starch or potassa sulphurata (2 ounces to 30 gallons of water), followed by a rubbing with a lotion of carbolic acid and glycerine, or smeared with a 2 per cent. salicylic vaseline. Ointments of carbolic acid and salicylic acid are often useful. Menthol is not of much service. In the severe form much good often results from swathing the affected parts with lint soaked in glycerine of lead (1 ounce to 20 of water). Internally the author has found the greatest benefit from antipyrine (20 or 30 grains at bed-time), which may be repeated each night in chronic cases. Salicylates, atropine, bromide of potassium (with or without atropine) are all recommended. In gouty cases, or when there is defective action of the kidneys with lessened excretion of urea, colchicum has been found valuable. Pilocarpine also is sometimes found to be useful.

### Odorless Iodoform.

Iodoform, it is said, can have its disreputable odor successfully masked in the following combination: Iodoform, powdered benzoin, powdered cinchona, and magnesium carbonate, equal parts, and a little oil of eucalyptus. The formula is credited to Lucas-Championniere.—*Ex.*

# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*March 9, 1894.*

STENOGRAPHICALLY REPORTED BY C. C. MAPES.

### MICROCEPHALUS.

DR. A. M. VANCE: This patient is three years of age, and my object in presenting the case is to make a continued report. It is a typical case of microcephalus. On the fifth of April last, I opened one side of the head, and on the sixteenth of the following June operated upon the other side. It has now been nearly a year since the first operation, and there has been practically no improvement in the child's condition. There was no unfavorable symptom following either operation; the child left the hospital each time on about the sixth day, and both wounds healed perfectly. One rather pecul ar feature about this case is that the child has never been induced to partake of anything in the way of food except milk, and that is taken from a bottle. The mother reports that she has never been able to persuade the child to take any solid food.

As I stated at a previous meeting of this Society, I have come to the conclusion that craniectomy for microcephalus is an unjustifiable operation. This conclusion has been reached from my observations in the two cases upon which I have operated, and from reports of others who have done the operation.

#### DISCUSSION.

DR. C. SKINNER: What result was noticed from the operation?

DR. A. M. VANCE: At the time I performed the first operation upon this child, I felt quite encouraged, as there seemed to be an indication of improvement in intelligence, but now after nearly twelve months have elapsed, I fail to see any improvement whatever. Epileptic seizures still occur; they have been somewhat modified under the administration of bromides, but as soon as the bromides are withdrawn the attacks return.

DR. WILLIAM CHEATHAM: I looked at this child's eyes, and from the restlessness exhibited to-night, may be imagined the difficulty experienced in making an ophthalmoscopic examination; I was finally able to get a reasonably satisfactory view, and am satisfied that there is atrophy of both optic nerves. The mother states to-night that she thinks there is some vision. She bases this statement upon the fact that when the child is lying quietly on the bed, and she is moving about the room, the child seems to recognize her presence as she comes closer to it. I doubt if there is any vision at all, as we know there are other means by which a child can recognize its mother's presence. The optic nerves are perfectly white.

### TRAUMATIC ANEURISM.

DR. A. M. VANCE: At the annual meeting of this Society, last may, Dr. Turner Anderson exhibited a patient having traumatic aneurism of the femoral artery. I present the patient now to show the result of removal of the aneurism by dissection, and also show the specimen.

The history of the case is that the patient, about two and a half years ago, while working with a hammer and chisel upon a piece of steel, a piece of the hammer or steel flew off, penetrating his thigh. The bleeding was quite excessive, but he was seen soon afterward by his physician and the hemorrhage stopped by a compress. Subsequently the aneurism developed. On September 19th, 1893, I dissected out the aneurism carefully, and exhibit both the patient and the specimen. He has had a pretty rough time of it. Both the vein and artery were involved—aneurism of the femoral artery and a varix condition of the large vein in that situation—requiring a very careful dissection. I dissected the whole mass and applied a ligature above and below. On the twenty-third day after the operation he had secondary hemorrhage due to the fact that the femoral was double, commencing just above the aneurismal sac, and the ligature was applied so near the bifurcation that it was not permanent. There was no swelling of the foot on that side due to the ligation. It is evident in this case that collateral circulation had already been established. It was necessary to make a long incision to get sufficient space in which to work, and altogether the operation was a very difficult and tedious one. I believe complete dissection of the aneurismal sac is the best treatment of this condition, and the result in this case shows the wisdom of it.

#### DISCUSSION.

DR. A. M. GARTLEDGE: I agree that the probable cause of the secondary hemorrhage was that the ligature was applied so close to the bifurcation of the artery. This is evident from the fact that there was a little leakage on several occasions. I also agree that there is only one way to treat these aneurisms and that is to completely dissect out the sac.

Dr. T. L. McDermott read an essay on

APPENDICITIS FROM A MEDICAL STANDPOINT.

(See page 813)

DISCUSSION

DR. A. M. VANCE: I agree with McDermott that appendicitis is one of the most interesting subjects before the medical and surgical world at the present time. The question arises in each case whether it is a case for the physician or surgeon, and I must say at the beginning that I think one of the greatest faults in the outcome of a great many of these cases is that the doctor does not call the surgeon sufficiently early. I have operated for appendicitis ten times and lost four patients. Of the four patients that died, two were the subjects of general peritonitis, and were practically moribund before the operation was performed. In one case the first symptoms had appeared about eighteen hours before; the other, about three days. I believe if both had been operated upon at the very onset, they would have been saved. Of the other two cases, one was in active sepsis at the time of the operation; Dr. Bailey and several of the other members present witnessed the operation. The man died from sepsis, without the paresis of the bowel that we nearly always see, because the bowels moved freely and there was no tympanites at any time. I believe firmly that unless a case of supposed appendicitis is practically well in twenty-four hours from the first symptom that attracts attention, an operation should be performed. It is my opinion that this will be the treatment hereafter. Surgical statistics are positive; while statistics from a medical standpoint are of no value whatever; because the ordinary medical man (without operation) cannot tell absolutely whether his patient had appendicitis or not. In proof of that fact, Richardson has gone over the death statistics of Boston, Cambridge, and various other cities in that section, and the facts show that the death rate in adult males from *peritonitis* in the last decade has been very great. What else in the young male can produce peritonitis except appendicitis, excluding traumatism? I am appointed to write a paper upon the "Determination for Operation in Appendicitis" for the next meeting of the State (Kentucky) Medical Society, and I believe the whole subject can be covered in one line—"Diagnosis; then Operation."

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# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*March 9, 1894.*

STENOGRAPHICALLY REPORTED BY C. C. MAPES.

### MICROCEPHALUS.

DR. A. M. VANCE: This patient is three years of age, and my object in presenting the case is to make a continued report. It is a typical case of microcephalus. On the fifth of April last, I opened one side of the head, and on the sixteenth of the following June operated upon the other side. It has now been nearly a year since the first operation, and there has been practically no improvement in the child's condition. There was no unfavorable symptom following either operation; the child left the hospital each time on about the sixth day, and both wounds healed perfectly. One rather pecul ar feature about this case is that the child has never been induced to partake of anything in the way of food except milk, and that is taken from a bottle. The mother reports that she has never been able to persuade the child to take any solid food.

As I stated at a previous meeting of this Society, I have come to the conclusion that craniectomy for microcephalus is an unjustifiable operation. This conclusion has been reached from my observations in the two cases upon which I have operated, and from reports of others who have done the operation.

#### DISCUSSION.

DR. C. SKINNER: What result was noticed from the operation?

DR. A. M. VANCE: At the time I performed the first operation upon this child, I felt quite encouraged, as there seemed to be an indication of improvement in intelligence, but now after nearly twelve months have elapsed, I fail to see any improvement whatever. Epileptic seizures still occur; they have been somewhat modified under the administration of bromides, but as soon as the bromides are withdrawn the attacks return.

DR. WILLIAM CHEATHAM: I looked at this child's eyes, and from the restlessness exhibited to-night, may be imagined the difficulty experienced in making an ophthalmoscopic examination; I was finally able to get a reasonably satisfactory view, and am satisfied that there is atrophy of both optic nerves. The mother states to-night that she thinks there is some vision. She bases this statement upon the fact that when the child is lying quietly on the bed, and she is moving about the room, the child seems to recognize her presence as she comes closer to it. I doubt if there is any vision at all, as we know there are other means by which a child can recognize its mother's presence. The optic nerves are perfectly white.

### TRAUMATIC ANEURISM.

DR. A. M. VANCE: At the annual meeting of this Society, last may, Dr. Turner Anderson exhibited a patient having traumatic aneurism of the femoral artery. I present the patient now to show the result of removal of the aneurism by dissection, and also show the specimen.

The history of the case is that the patient, about two and a half years ago, while working with a hammer and chisel upon a piece of steel, a piece of the hammer or steel flew off, penetrating his thigh. The bleeding was quite excessive, but he was seen soon afterward by his physician and the hemorrhage stopped by a compress. Subsequently the aneurism developed. On September 19th, 1893, I dissected out the aneurism carefully, and exhibit both the patient and the specimen. He has had a pretty rough time of it. Both the vein and artery were involved—aneurism of the femoral artery and a varix condition of the large vein in that situation—requiring a very careful dissection. I dissected the whole mass and applied a ligature above and below. On the twenty-third day after the operation he had secondary hemorrhage due to the fact that the femoral was double, commencing just above the aneurismal sac, and the ligature was applied so near the bifurcation that it was not permanent. There was no swelling of the foot on that side due to the ligation. It is evident in this case that collateral circulation had already been established. It was necessary to make a long incision to get sufficient space in which to work, and altogether the operation was a very difficult and tedious one. I believe complete dissection of the aneurismal sac is the best treatment of this condition, and the result in this case shows the wisdom of it.

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treatment of so-called appendicitis, and have never had a case die. Perhaps they were simply cases involving the cæcum, yet local peritonitis developed in some cases. Frequently I have seen marked tumor in the appendicular region with constitutional impression, elevation of temperature, quickened pulse, tenderness on pressure and rigidity of the muscle, etc. Yet I do not know whether they were appendicitis or not.

DR. J. G. CECIL: I have no very pronounced opinion in regard to appendicitis because my individual experience in that direction is very limited. Like my friend, Prof. Bailey, I have never seen a case in my own practice that I can say positively was appendicitis. Those cases that I thought were appendicitis have recovered without operation. In the cases that I have seen, operation has not been indicated; the cases that I had every reason to believe were appendicitis have gotten well without it. However, I recognize the fact, which is established beyond any reasonable doubt, that many of these cases do necessarily require an operation to save them. Any opinion of a given case that I might have would, of course, be based upon the diagnosis of the case. My judgment as to operation would depend upon the diagnosis, and I am prepared to say if I were called to see a case of supposed appendicitis and could make out from the symptoms and history of the case that suppuration or perforation had occurred, I would not hesitate a moment in advising an operation. Until this feature could be substantiated I should be inclined to hesitate. I do not believe that every case of *supposed appendicitis* requires operation at once. It all depends upon the diagnosis. If a case of suppurative appendicitis is established beyond question, then an operation is demanded; but neither the surgeon nor the physician, to my mind, has yet given us a schedule of diagnostic points which will enable us to say one way or the other just what is the proper procedure. Notwithstanding the very pronounced and decided views taken by both sides, I am still "on the fence."

DR. J. L. HOWARD: I certainly think that appendicitis is a surgical disease so soon as the diagnosis is made, and should be operated upon without further delay. I have been unfortunate enough in the last year to have had two cases of appendicitis, one operated upon the other not. The first case was a young man whom several of the Fellows will doubtless remember. He was taken on Wednesday with pain in the right iliac region; there was no tumor, the pulse was not accelerated, and the temperature up to the time collapse came on, did not exceed 101° F. The next morning (Thursday) I made diagnosis of appendicitis; I did not pay any attention to McBurney's point, because I do not see how we can expect to have any defined point in an organ as large as the cæcum, when it varies so much in shape from distension, etc. The diagnosis I made was catrrhal appendicitis, which I shall always regret because I think it is very misleading and we should not classify appendicitis as catarrhal. It does not matter what the nature of the inflammation in appendicitis is, it should be operated upon. I called in a surgeon immediately who agreed with me in the diagnosis, but as the patient had a pulse of 74 and was getting along so nicely, he advised waiting a day or two before operating. The case went on until Saturday night, when suddenly symptoms of general peritonitis set in, perforation evidently having taken place. Owing to the time of night I was unable to get a surgeon immediately, and operation was not performed until the next day. The patient was in collapse at the time.. Right here is an important point: If I were a surgeon I would never operate upon a patient in collapse. The operation was quickly completed and the patient died a short time afterward. The other case had a similar history, and showed about the same condition. In both cases the appendix was almost entirely destroyed. In the last case it was very hard to find the appendix, only a small portion of it being left, and the cavity was filled with pus.

DR. TURNER ANDERSON: I have expressed myself so often upon this subject before this Society that I feel I have little to add to what I have already said on the question of appendicitis. I can talk only about my own experience, what I have seen, etc., and perhaps there will be little interest attached to it. I say now, as I have on a great many occasions, that the reports and specimens that have been presented at different times have not changed my views in regard to this trouble.

The first case of appendicitis I saw was in 1866, it was then called perityphlitis. That man is alive and well to-day. The name "appendicitis" was not known at that time, the nomenclature has been changed since. From that time to the present I will say that I have never seen a case not operated upon which terminated in abscess or in death. Within four months of the present time I saw a little girl ill with abdominal pain, having a tumor as large as a man's fist immediately beneath the McBurney point, that went on with dysenteric symptoms until it looked very much like a case in which an abscess had formed, and that operation would be nothing more than opening an abscess. Dr. W. O. Roberts saw the case with me. The child's pulse was good, inspection of the abdomen showed the tumor—it was not neces-

sary to palpate as it could be plainly seen. We concluded to wait until the next day, and the day following we waited again. There was a sudden subsidence of the pain and discomfort, the tumor entirely disappeared and the little girl made a perfect recovery. Her temperature on several occasions was 103° F.

Nine months ago I was asked to see a case with Dr. Roberts, a little Jewish child. The patient was lying in bed, with the leg flexed and all the evidences of perityplitis abscess, tumor quite large. The mother strenuously objected to any operative procedure, and I told her that I belirved the child would get well if let alone. I was not sent for in consultation at request of Dr. Roberts, but was asked by the people. I believed that the child would get well and wouid not force the operation. That child is running about now, going to school.

From 1866, when I saw my first case, up to the present time I have not seen a case that has terminated in suppuration, nor terminated in death, which was not operated upon. That is a queer personal experience. I do not mean to criticise the surgeons on the subject, nor their operative procedures; I simply state facts.

Some months ago I thought Dr. Cartledge had advanced views which were entitled to most important consideration. He suggested that the appendix was an organ which had some special way, when attacked with catarrhal inflammation, of getting rid of that inflammation by discharging into the cæcum—some special way which was not understood. I thought it might be possible for the appendix to fill up with a semi-liquid material and form a tumor without closing the proximal extremity of it. I thought there might be something in what Dr. Cartledge said, and the course he suggested might be pursued, which would explain recovery of some of the cases treated medically. I was much surprised at the last meeting of this society, when Dr. Cartledge, without prefacing anything he had previously said on the subject, exhibited a specimen of an appendix he had removed (the man having presented symptoms of recurrent appendicitis) calling attention to stenosis of the proximal extremity of it. I could not see anything the matter with it. I could not see anything abnormal about it simply from an occular inspection. There had been no perforation of that specimen. So that my idea is that it was a case of catarrhal appendicitis, where the tumor had discharged into the caecum, the accumulation having been gotten rid of in that way. Though Dr. Cartledge declared there was no such thing as "catarrhal appendicitis," he presented an appendix which, so far as I could see, had nothing the matter with it. It shows how difficult it is for us to arrive at a satisfactory classification, or to intelligently discuss this subject from a pathological standpoint. Therefore, discussion of the subject from a clinical standpoint at the present time is the only standpoint from which we can get any special information. I believe if I were called upon to demonstrate whether an operation should be performed for appendicitis in an individual I had a great deal of interest in, I would decide in the negative. I have seen a great many cases of appendicitis; have been present at the operation; have seen the appendix removed and have not seen positive evidence of disease, nor evidence sufficient, in my judgment, to justify operation. And, as I say, I have not seen a case terminate fatally which was not subjected to operation.

There is one case to which I want to call attention without mentioning any names, where I think a man would have had better chances of life if he had not been operated upon. He was a beer drinker. Obese, flabby, had a weak heart, a depressed nervous system, and perhaps kidney trouble in addition. I think that man would have stood a much better chance to have gotten well if he had been let alone. He died soon after the operation, and so far as I am able to offer an opinion, there was nothing in the appendix that could have caused the symptoms under which he was laboring at time of the operation. I believe that operations for appendicitis are being performed too frequently; that there is entirely too much being done in this line. This thing of talking about recurrent attacks of appendicitis and operation to prevent the dangers that may come, I think is a grave mistake, and I believe it is a great deal better to trust to our old methods of treatment in these cases than it is to open the belly upon the slightest evidence of pain or distension. There are a great many people who suffer from constipation, indigestion, flatulency, etc., which might cause the same amount of pain and tenderness, and I believe that many mistakes are made when the belly is opened. It is a very difficult question, as the essayist has said, to determine what the condition is; I believe in a great many cases those conditions which were supposed to have been the cause of the disease are largely *post-mortem*.

DR. E. R. PALMER: I would like to ask Dr. Vance the final outcome of the case (Mr. W.) he operated upon some time ago for appendicitis?

DR. A. M. VANCE: The history of that case was that the man had suffered several attacks of severe pain, and everything pointed to appendicitis. At the operation, from a macroscopical examination of the appendix, I did not think it was diseased, but the microscope revealed that it was in a state of

active inflammation. The man has had a similar seizure since the operation, and there must, of course, be something outside of the appendix as a causative agent. He is a very nervous, hysterical man.

DR. A. M. CARTLEDGE: Did Dr. Anderson take the trouble to examine two other specimens I exhibited at the last meeting of this Society? He only mentions one. If he had examined the other specimens he would have observed a pathological condition certainly demanding operation. One was a large perforated appendix, and the other a necrotic stump of appendix with fecal matter pouring in the surrounding abscess.

DR. TURNER ANDERSON: I think those specimens were undergoing a form of resolution which may be common in tumor cases. Very recently I was asked to see a woman where I believe such a condition existed.

DR. A. M. VANCE: Did not Dr. Anderson see pus in the belly of a case of appendicitis upon which I operated in his presenee some time ago?

DR. TURNER ANDERSON: I do not remember to have seen any pus; there may have been the remains of a hematocele, but I believe the appendix was in a healthy condition. I did not examine the specimen Dr. Cartledge presented with a great deal of care, but I could see no pus or anything else to indicate disease. I do not know whether rupture had occurred or not, or whether there had been an inflammatory exudate outside which had marked the effusion of pus. I asked him where the morbific evidences were, and he said I would have to take his statement that the appendix had contained liquid feces, etc. I told him that I would accept the fact that it was a case of appendicitis, and asked him to point out the point of stenosis which was supposed to be near the proximal extremity. He made the attempt, but I was unable to see anything wrong with it.

DR. J. L. HOWARD: How many cases has Dr. Anderson seen in which he has noted the formation of pus, or an abscess causing general peritonitis?

DR. TURNER ANDERSON: I have never seen a case terminating in suppuration or death.

DR. C. SKINNER: I do not know just where I do stand on this subject. It strikes me, though, that since the matter has been brought up, it has about resolved itself into a factional discussion. I am going to claim to belong to both sides. Some of you know that I sometimes do work in this line, and I also practice medicine. It would be a very hard matter to reconcile the statements made by the different speakers, but when we hear the statement from such men as Drs. Bailey and Anderson, who have been thirty-five and twenty-eight years respectively in active practice, that operation in the majority of these cases is not required, it would seem that their views are entitled to mature consideration. I am going to bore you with the recitation of two cases; one operated upon followed by recovery, the other not operated upon also got well.

The first case was a very thin woman, seen by me three years ago at the city hospital. She was about thirty years of age, and one peculiar feature was that she had no teeth. She was suffering at the time from what appeared to be an undoubted attack of appendicitis. She was carefully watched by both myself and the Interne. There was an exquisitely tender spot in the right side of the abdomen at about the McBurney point. In the first attack, under the application of cloths wrung from hot water to which had been added a little turpentine, all tenderness disappeared. I kept her under observation for two months, and in this time she had three attacks of this sort, and I pronounced the trouble fermentative indigestion. The woman, on account of the absence of teeth, was not able to masticate her food at all. As stated, diagnosis had previously been made of appendicitis. This woman became apparently well, but I left her in the ward at the expiration of my term of service. I did not operate upon her. My successor took this patient out of the hospital—some repairs were being made and it was deemed wise not to operate in the hospital—and removing her to one of the Infirmaries, operated for appendicitis. I was not present at the operation, and did not see the patient until several days afterward. From those who did see the operation I learned that the appendix was in a normal condition. Shortly after the operation and before the stitches were removed, she had another attack of the same character, and came very near dying. She finally recovered from the effects of the operation and went to Indiana. Last year, during my service at the City Hospital, this woman turned up again. She came into the ward and said that she had been having those attacks right along since the operation. I then secured for her a set of false teeth, and after several trials we succeeded in getting a set that would fit. Then arose the difficulty of getting her to properly masticate her food with the new teeth. I practiced the lavage treatment of the stomach, and up to the time I left the ward no more attacks had occurred. In about a month absolutely all evidence of trouble ceased.

No. 2.—In June I was called to see a young woman in this city who had always been the perfect picture of health, and another physician, her relative, had attended her for three days when I was called. She was taken ill very suddenly with intense pain in the right

iliac region. At the time I saw her she had been given a cathartic, the bowels h ad moved freely, but there was no cessation of pain. The pain increased and though the bowels were still open the temperature ran up, reaching 106° F., with a tumor in the right iliac region seemingly the size of two fists. I recognized the gravity of the case and called Dr. Bailey in consultation at once. I had already planned out a line of medical treatment—the use of opium and hot applications. This woman went along for two weeks under that treatment, making a good recovery, and is well now. Here was a case of unmistakable appendicitis which recovered under full doses of opium, keeping the patient sleeping nearly all the time, and the use of hot applications, changing these every thirty minutes. The tumor disappeared and in two weeks she was up.

I hardly know where I stand on a question of this sort. I believe, though, where there are unmistakable signs of pus, or any evidences of perforation, that operation is justifiable.

[Continued in issue of June 16th.]

## CINCINNATI OBSTETRICAL SOCIETY.

### OFFICIAL REPORT.

*Meeting of February 22, 1894.*

Dr. E. G. Zinke exhibited the following specimens:

FIBRO-CYSTIC TUMOR OF THE UTERUS.

This specimen was removed from a patient who presented herself at the German Hospital a week ago last Tuesday, the 13th of this month:

Mrs.—, age forty-seven, very much emaciated, which made the presence of an abdominal tumor quite perceptive; mother of but one child, born twenty years ago. Never had a miscarriage. Has not felt well since the birth of the child. The first appearance of the tumor was noted some eighteen years ago, having grown steadily until it attained its present large size, filling up, as it did, the whole of the abdominal cavity. The tumor was fluctuant two inches above the symphysis, and absolutely solid below that point. The sold mass of the tumor filled out completely the pelvic cavity, so that the os externum could notbe reached except by forcing the finger high up between the growth and the symphysis. The diagnosis was a fibro-cystic tumor, either of the uterus or ovary, or a fibroid tumor of the uterus complicated by a large ovarian cyst. The patient was very weak; her temperature ran up every afternoon to 101°; pulse 130, wiry and compressible. It was evident from her general condition that her days on earth were few if not relieved from this growth. Her physical condition was such that even operative interference promised very little. However, the family, as well as the patient herself, embraced the only opportunity that was left. She was operated upon the 16th of this month. A free incision was made in the median line, probably seven to eight inches in length. A cyst universally adherent presented itself. The adhesions were very strong, firm and exceeding difficult of separation. The tumor was punctured with a trocar, with a view of emptying it and in this way facilitate removal. A large amount of chocolate-colored fluid escaped. After reducing the tumor in size, I found it impossible to separate the adhesions, and most of them had to be ligated and severed by the knife. After the tumor was freed anteriorly, and from the omentum and intestines above, I attempted to get my hand behind the tumor to separate the adhesion In this attempt I broke through the cyst, and its contents freely flooded all of the abdominal viscera. After a good deal of hard and persistent work I succeeded in eventrating the growth, but it proved absolutely impossible to liberate the solid portion from the pelvic cavity, and was obliged to fix this large and solid mass in the abdominal wound, abandoning the idea of liberating the tumor entirely. A clamp was put around it and the tumor transfixed. About twenty hypodermic injections of whiskey, as well as a transfusion of sterilized salt water solution, had to be made to keep the patient alive long enough to get her off the table. The following morning the temperature was 99°, the pulse 130.

She died of exhaustion forty-eight hours after the operation. The fluid removed from the cyst consisted of degenerated fat globules; no streptococci could be discovered. The tumor had its origin in the posterior wall of the uterus.

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TOTAL VAGINAL HYSTERECTOMY OF A FIVE MONTHS' PREGNANT UTERUS FOR CARCINOMA COLLI.

The other specimen which I would present this evening is the contents of the uterus, removed after I had extirpated the uterus per vaginam. The patient was a woman, age thirty-nine, the mother of a large family, the youngest of which was only four years of age. The patient was referred to me by Dr. Koehler, of this city, who had made a diagnosis of epithelioma of the cervix. Upon examination I confirmed his diagnosis, and we determined to make a vaginal hysterectomy. There was some suspicion at the time that this woman was pregnant, but upon digital examination I could not feel the fundus of the uterus. She is a very large, heavy, fat woman, and I expressed it as my opinion that she was not pregnant, although I did not preclude the possibility of it. She had bled constantly, because of the cauliflower excrescences in the cervix. I operated a week ago last Saturday, at the German Hospital. After I had separated the cervix from its attachments I tried to pull the organ down. I could not feel the end of the uterus, and the organ was quite soft, and I recognized the fact that she was pregnant. Of course there was no use of hesitating any longer, and I had to put on the clamps and remove the whole pregnant uterus. I did not apply any ligatures. After we removed the organ we incised it and removed a four months fetus from it. The patient is now virtually well. She did not suffer from shock any more than a woman ordinarily does from an operation of this kind. It is highly probable that, had I known of the existence of pregnancy, we would not have operated upon this woman, and yet had we done so we would certainly have placed her life in great jeopardy, because the result would have been inevitable. Had this woman advanced to full term we would have been obliged to have made Cæsarean section, and the disease by that time would have made such inroads as to preclude the likelihood of a recovery. So, notwithstanding I did this without being in the possession of all the facts of the case, I have done the very best thing that could possibly have been done for her. She has not had an untoward symptom at any time.

The first specimen presented itself to me in this way: Had I been politic, or permitted policy to actuate my conduct in the case, I should have preferred to send her home without an operation, but it appeared to me to be an act of cowardice not to make an attempt; for, although the appearances are unfavorable, it seemed to me to be my duty to present the case to her friends and leave it to them to refuse or accept.

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**The Electrical Treatment of Infantile Paralysis.**

Dr. Lewis Jones, at the London Medical Society, March 5 (*The Lancet*, March 10th, 1893) read a paper on the above subject based upon an extended experience in the Electrical Department of St. Bartholomew's. His conclusions are that prolonged electrical treatment would do much good in nearly all cases, providing that the children were young and that not more than three years had elapsed since the incidence of the disease. He assumes that in many cases a considerable number of muscular fibres, damaged perhaps, but not destroyed, remain in the affected muscles, and that the motor or ganglion cells in the anterior horn of the spinal cord, which supply the muscles have a considerable vertical space and many of these might thus escape destruction. His purpose appears to be to bring the fibres which may happen to remain to the highest possible state of nutrition by applying treatment directly to them; if he expects to improve either directly or indirectly the cell in the cord he makes no suggestion of it. He divides the cases into two types.

The electrical treatment is to be applied twice a week, and the affected limbs bathed in warm water and well rubbed every night. Any form of electricity is of value which will stimulate living tissues, but if it has to be placed in the hands of the mother, faradism is best because most easily managed. Care should be taken not to frighten the child by sudden shocks. He summarizes as follows; 1. It is important in every case of infantile paralysis which has lasted for more than four weeks to try electrical treatment for six months or a year, if necessary. 2. It is exceptional for the muscles to be so completely destroyed as to have no functional fibres left. 3. A great development of these remaining fibres might be gained by a preseverering stimulation of them by electricity. 4. When the electrical reaction is entirely absent or reduced to the lowest point some improvement may still be hoped for.

# THE LIBRARY TABLE.

## BOOK REVIEWS.

*An American Text-book of the Diseases of Children*, including special chapters on essential surgical subjects: diseases of the eye, ear, nose, and throat; diseases of the skin; and on the diet, hygiene, and general management of children. By American teachers. Edited by Louis Starr, M. D., assisted by Thomas S. Wescott, M. D. Published by W. B. Saunders, 1894.

The diseases of children, though a part of the study of general medicine, form a chapter in the healing art which is more or less distinct and separate from the rest of the subject. The symptoms, the cry, the cough, the expression of the face, all demand a special interpretation in babies which is not furnished by our knowledge of the diseases of adult life. For better understanding of the subject, therefore, we naturally look to the works of eminent authors; and since the tendency of the day is toward specialties, we rightfully expect from the pens of these specialists a terseness and exactness of statements which we can rely upon in any emergency.

The present volume is really an encyclopædia upon the diseases of children, embracing all that has proved valuable knowledge in the hands of no less than sixty-three American teachers, including the most eminent authorities on their respective subjects that the country has produced, among whom may be mentioned such names as Pepper, Ashurst, Da Costa, Gray, Hirst, Osler, White, Griffith, Deaver, and a host of other men holding prominent teaching positions in the leading medical colleges of America.

The work is edited in a masterly manner by Dr. Louis Starr, of Philadelphia, who has, in addition contributed chapters upon the discussion of "*Simple Atrophy*," "Measles," and the "Clinical Investigation of Disease and the General Management of Children."

Among the more strongly written chapters may be mentioned those of Osler's article upon tuberculosis, in which the most practical points are as to prophylaxis and treatment. The former consists in the destruction of the sputa and the disinfection of milk by boiling, when the source of the milk is of doubtful purity. The treatment he resolves into three essentials—sunshine and fresh air, nourishing food, and reconstructive tonics, such as cod liver oil, hypophosphites and creasote.

Starr's article on "Measles" is to the point, and at the same time written in an easy, agreeable style. The chapter on "*Simple Atrophy*" is condensed into five pages.

Among the other attractively written parts of the book may be mentioned the contributions of Ashnrst on "*Appendicitis*" and "*Intussusception*," respectively. The nine chapters by Chas. K. Mills, especially those upon "*Headache*" and "*Insanity*," and of William White's "*Vesical Calculus*" and *Gonorrhœa*."

The work is printed on excellent paper in large, clear type, and is profusely illustrated; and in every respect deserves a first place in the physician's library. W. H. H.

*The Standard Dictionary.*

The announcement is made of the completion of Volume 1, of the Funk & Wagner Standard Dictionary, and the statement is made that the second volume will be completed during the year 1894. An examination of the volume shows that it will meet the daily needs of the reader, perhaps better than any other dictionary in existence. It certainly will prove of invaluable service to all English students. It is the result of more than four years of constant labor by two hundred and forty-seven office editors and specialists, assisted by hundreds of other men and women. The estimated cost of the dictionary is over one million of dollars. The vocabulary is extraordinarily rich and full. The number of words and terms found in the Standard Dictionary is nearly three hundred thousand.

There are certain distinguishing characteristics of the work which greatly add to its value. For instance, in definitions of words, the most common meaning is given first; that is, preference is given to the order of usage, rather than the historical order generally followed in other dictionaries. The etymology is placed *after* the definition; a great convenience for ready reference. In the pronunciation of words, the scientific alphabet prepared and recommended by the American Philological Association is used. The quotations in the work, are located by book, page and edition from which the quotation has been taken. By a simple and comprehensive system, the best judgment of the English speaking world on all disputed points of pronunciation and spelling is clearly indicated to the reader. A systematic treatment of the compounding of words has been thoroughly undertaken. Obsolete, foreign, dialectic and slang words are given places only if likely to be sought for in a general English dictionary. Great care and labor has been bestowed upon every page and every article. Specialists in every department of science and learning have supplemented the learning of the editor-in-chief and his immediate associates.

A marked feature of the dictionary is found in the magnificent illustrations especially prepared for the work. For instance, under the heads of Architecture, Coins, Fowls,—fine illustrative plates have been prepared which greatly aid the reader, and are in themselves an education on the subject treated. Under the word decorations a handsome colored double plate shows the various decorations of honor used in the world. Under the title of Flag, the various flags of the world are exhibited, under the title of Gem,

a remarkable plate is given, showing the various colors and forms of the leading precious stones.

In technical and scientific matters, the Dictionary is far in advance of any other published. It is without doubt the best working dictionary that has yet appeared. Its scope appears to be almost unlimited, and the work is as complete and reliable as possible. It is a great monument of exact scholarship; and it is not too great praise to say it is the best of English dictionaries. We unhesitatingly commend it to our readers as the Standard dictionary of the English language. It will be published in a single volume, as well as the two-volume edition. A. G. K.

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# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

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THE ANNALS OF GYNÆCOLOGY AND PÆDIATRY

for May. Dr. A. H. Buckmaster discusses

**Hemorrhage after Abdominal Section: Its Place in Statistics.**

The author is of the opinion that the reason that so little is heard of the deaths after abdominal section lies in the fact that men report only their successful cases and try, as much as possible, to make their results conform to the low rate of mortaliy that those expert in the operation have set. The author says, that since he has had the misfortune to lose a case from hemorrhage after operation, he has had over forty such cases narrated to him by almost as many operators. All of these cases are unpublished.

The author is further of the opinion that the drainage tube as a means of detection of hemorrhage has been overestimated, though in rare instances it may be of service. In support of this he quotes the experiments of Delbert both on dead subjects and dogs, in which it was found that it is almost impossible to keep the peritoneal cavity in communication with the open end of the tube, for if the intestines do not crowd into the end of the tube, it is soon sealed off by the exudate. The author is aware that this is not the general view of the profession, but, nevertheless, it has been borne out by his experience.

In studying the cases which he has been able to collect, the author has noted the following facts:

The greater number arose from the slipping out of the hypertrophied broad ligament from the grasp of the ligature. Next in importance to this cause was the reliance on pressure by means of sponges or gauze. Two cases were due to the slipping of a clamp after hysterectomy. A cause of hemorrhage to which the author claims to have first directed the attention of the profession, is occasioned by the use of the Trendelenberg position. In this position the flow of blood may not be noticed, because, with the hips elevated, the blood pressure in the pelvis is much reduced; but let the pressure be increased, by placing the patient in a horizental position, and the hemorrhage may become free. But of all the cases given none are so fruitful in occasioning disaster as those which presented a broad stump that contained hypertrophied broad ligament.

From his own experience and that of others, the author has come to the following conclusions:

1. When the abdomen is closed after section the case is closed. No treatment short of that which is aggressively bad will influence the after-result. Nothing, therefore, should be left undone with the reservation that the case may require reopening. It is often better to run the risk of death from shock than the risk of death from hemorrhage. Many of the fatal cases were the result of that state of mind which the operator revealed when he said "I was afraid that the patient would die on the table, and therefore quickly terminated the operation by pressure on the bleeding-points by the gauze drain or sponges."

2. When symptoms of concealed hemorrhage are present it is too late to afford the patient more than a forlorn hope.

3. The use of the drainage-tube to indicate hemorrhage is not to be relied upon.

4. It is best, when possible, to enucleate all cases where the hypertrophied broad ligament forms a part of the pedicle.

5. In all cases of suspected hemorrhage the pelvis should not be elevated, for in this position the blood will gravitate out of the pelvis and collect under the diaphragm, where it is impossible to remove it without eventration. This blood will in many cases set up a peritonitis, and it is this peritonitis which it has been blamed for many deaths due primarily to hemorrhage.

6. That a patient may have no bleeding in the pelvis when she is in the Trendelenberg posture, because the arterial pressure is diminished; but when the pelvis is lowered, bleeding of a dangerous character may occur.

Dr. William Wotkins Seymour reports

**Three Successful Cholecystotomies for Gall-Stones,**

with remarks based on six cases. The author feels that excision of the gall-bladder has no field save in gangrene or malignant disease, because its removal does not remove the laboratory in which the stones are formed. He also believes that the performing of the operation in two stages is a retrogression, markedly circumscribing our field of action in the cases with complications which are not to be foreseen and certain to result in incomplete and discrediting operations. The belly can by aseptic pads be thoroughly safeguarded

against bile, and the operation in two stages has no advantages which the simple operation does not possess many times over. The author prefers the incision parallel to the liver border to all others. This oblique incision gives the most perfect access to the gall-bladder and ducts of any incision that the author is acquainted with, at the same time admitting of perfect coaptation with a minimum danger of hernia.

Between cholecystotomy with suture of the viscus to the parietes and cholecystotomy with suture and dropping of the gall-bladder, leaving the peritoneum undrained, he believes the advantage to lie with the former. When the gall-bladder can be sutured well, he can see not only no objection, but an advantage, if the belly is safeguarded by temporary drainage and tamponade. If the stitches hold, the tube can be withdrawn in a few days at least, and convalescence materially shortened. In the cases where it is impossible to bring the gall-bladder into the wound, or where we are obliged, after failing in crushing or needling stones in the common duct, to excise them we can, according to the facility with which it can be done, either suture the opening, safeguarding it with drainage, or we may simply introduce a tube onto the opening and surround the tube with gauze till the belly is shut off. In cases where a fistula persists and proves detrimental to the patient's health, cholecystoenterostomy ought to be done, and the most rapid method seems to be with the Murphy's button. The use of the button, the author thinks, to sidetrack, without removing, stones obstructing the common duct is, in view of the irritative effects of gall-stones, an abuse of an instrument which promises much in its proper field.

The author is of the opinion that the time has come to regard gall-stones as a surgical affection; an affection which requires prompt intervention when the recurrences become at all frequent and severe. Neither Carlsbad water, nor olive oil, nor chloroform and turpentine can dissolve them when once formed, and to expose the patient to the many risks and unutterable tortures of many recurrences is downright wicked. Especially is this so when the mortality of the operations for this disease is extremely small.

Dr. Daniel Longaker, in a paper entitled

**Two Symphysiotomies and an Induced Labor,**

says, that his own personal decision would be not to employ symphysiotomy when the conjugate is below two and three-quarters inches (6.7 centimetres), but to regard the case as one demanding delivery by Cæsarean section under the absolute indication. The author believes that it is preferable to have a vertex presentation after symphysiotomy. Forceps should not be applied until the head has passed through the os, and not until bladder, anterior vaginal wall, and cervix have been retracted. In every case the author has thus far seen these structures accompany the head in its descent to the pelvic floor. In one the forceps were applied early and the head could be seen passing through the os outside vulva. Manually we can supply the support which is lost through the spreading asunder of the divided pubic bones, thus there will be secured less disturbance of the anatomical relations of the post- and infrapubic regions, earlier escape of the head through the os uteri, and less danger of laceration. Failure of fœtal vitality would indicate speedy extraction of the child by forceps even before descent and escape of the head from the os uteri.

Dr. George M. Boyd discusses

**Injuries to the Pelvic Floor and their Immediate Repair.**

The author believes that the forceps is the cause of many tears of the pelvic floor. In his experience we have a new factor in the axis traction rods of the modern instrument as the cause of these injuries. He cautions that the operator should be mindful that while he is making traction in the axis of the pelvic canal he may also be producing, by pressure, serious damage to the pelvic floor. The author also discusses the question as to whether the use of the bichloride douche is objectionable on account of drying the secretions of the vagina, though he comes to no conclusion in the matter. He states that even if it should be proven that the douche did dry or remove the secretions, he would yet favor its use on account as a prophylaxis against gonorrhœal, ophthalmia, and septic infection.

Perineal support has been of no service in his experience, except when extension of the head was favored by pulling the rectum forward. Direct pressure or guidance of the head presenting part in some cases seemed beneficial. In case of laceration of the perineum after labor, the injury should be immediately repaired under anæsthesia, and with this end in view the author has frequently commenced the use of the anæsthetic on the first evidence of injury, with the result that when the third stage of labor was completed the patient was fully under its control, thus avoiding delay. The suturing of the rent should begin from within out, and the first skin suture should be placed much as the crown stitch in the Emmet operation. The author believes that Chinese silk is better for suture material than silkworm gut. After operation the patient should be kept rigidly quiet—catherized every six or eight hours—given bichloride douche, 1 to 8000, daily. In the place of the ordinary vaginal iodoform suppositories, the author prefers the use of a pencil, 4 to 5 centimetres in length, made of iodoform grs. xxv, and sufficient starch and acacia to make the mass, when dry, hard, not easily broken. The advantage of the pencil over the suppository is, that while the suppository will dissolve within one hour and iodoform possibly escapes, the pencil will dissolve more slowly, requiring twelve hours. The pencil is also of advantage when it is desired to carry iodoform into the uterine cavity. The ordinary suppository melting or breaking to pieces in the grasp of fingers or forceps.

The author presents the following conclusions as the result of his experience:

First.—As every obstetrical case is greatly a mathematical problem, so is the safety of the pelvic floor; if the passenger is too large for the passage-way (something must give), a tear, either vaginal or perineal, will follow.

Second.—As it is our duty to study all obstetrical cases before labor by palpation and pelvinity, just as much is it our duty to examine the perineum and vagina after labor.

Third.—That having any injury of the pelvic floor, it should be at once repaired, and a good method to follow is to perform the operation under constant irrigation, using sterilized Chinese silk for sutures, and avoiding infection of the wound by placing the stitches without inserting the finger in the rectum.

Dr. J. A. Freeman contributes a paper on

**Retroversic Uteri.**

The only rational treatment, according to the author, is hysterorrhaphy, or ventral fixation; and he takes the stand that all cases of excessive retroversion should be subjected to this operation, which (according to him) is perfectly successful and safe when done under strict asepsis. The author further says that "Girls should be taught from early childhood to habitually lie upon the side, or, rather, sides alternately, and not in the supine position." The alternate sides should be used in order to produce symmetry of the body.

Dr. John G. Kerr, of Canton, China, concludes his interesting translation of

**The Tat Shang Pin.**

or midwifery made easy. The section on the regulation of the lying-in room is curiously like the same instructions one sees in modern books on the subject. The author states that when the period of confinement has come, two "of those steady, quiet, steady persons" must be selected to be in attendance. "There must not be too many, and it is better that they be relatives. They must with pleasant words request persons not to enter the room. In hot weather it is important not to have too many in the room, for the air becoming vitiated will be bad for the patient, and will cause giddiness, the evil effects of which will not be small. All persons in the room must walk lightly, speak gently, and must not indulge in much talking in order that the patient have quiet repose. It is of the utmost importance to exhort the patient to dismiss all fear, to be quite, to bear the pains, and not to be tossing about. Any remarks about strange and alarming things are especially to be forbidden, also whispering or sighing, for all these things cause her to be in doubt and troubled, and may result in evil.

"Everything in the room must be kept quiet, and in the patient's presence there must be no worshiping of the God, or making vows or invocation of heaven or earth.

"The midwife must enter the room alone, sit down quietly and not make confusion.

"A little food must be given to the patient frequently, such as chicken or duck, or the stomach and lights of hogs; but a little clear broth is better." Then follows certain rules for the determining of true from false labor-pains with reports of cases from the author's practice illustrating his meaning. Another section is "On Nourishing the Womb" while "Diet and Drinks" are discussed further on. Abortion is also considered. In regard to the after-treatment, the patient is instructed to get on the bed and recline on a high pillow, but is not to sleep. Her knees are to be flexed and she must drink a cup of child's urine (though for what purpose we are not informed). The attendants are not to disturb her by loud talking.

The cause of retention of the placenta is said to be because the birth has been forcibly brought on too soon. "During labor the joints are forced apart. In strong persons they close up in a few days, but in weak persons a month is required. Now, if the delivery is forced before the joints naturally open, they will close up again suddenly, so that the after-birth cannot come away." This condition is not considered dangerous. "There is no occasion for fear, and it is unnecessary to take medicine. When the after-birth does not come away, tie a hemp threaded to a fold of the cord and attach a weight to it to keep it from going back. Then cut the cord off short. In from three to five days the placenta will shrink up and come away. The patient must be plainly told not to be alarmed and that she must not listen to the midwife who will want to take it away with the hand, which would be the cause of much damage." Insufficient milk is said to be caused by thinness of the blood and directions for remedying it are given.

[The "Tat Sin Shang Pin" is a popular work on midwifery, in common use among the people of China, and is the standard authority in all difficult cases, so Dr. Kerr states in his translation of the first part of this work which appeared in the Annals of Gynecology for March. Dr. Kerr has endeavored to give a literal translation of the work, the author of which he could not discover, though in all probability the work is several centuries old. Dr. Kerr is to be thanked for giving the profession this curious insight into the teaching of a people that we are accustomed to regard as barbarians. He has already, in a paper read before the College of Physicians of Philadelphia, some years ago, giving an interesting account of operative obstetrics among the Chinese, and we look with interest for whatever he may have further to say on the subject.—Ed.]

The remaining papers in this issue are descriptions of a number of specimens removed by abdominal section, by Dr. William Easterly Ashton, and the discussion of "Fæcal Fistulæ," by Dr. Mordecai Price. In the "Department of Pædiatrics" is a clinical lecture by Dr. J. P. Crozer Griffith.

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**Cholera Infantum.**

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| Salicylate of bismuth | 4.0. |
| Prepared chalk | 2.0. |
| Tinct. canella | 1.0. |
| Peppermint-water | 10.0. |
| Malaga wine | 10.0 to 30.0. |
| Syrup acacia | 100.0 to 120.0. |
| Paregoric elixir | 10 drops. |

M. Sig.: A teaspoonful every hour.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Typhoid Fever.

Dr. Jno. Eliot Woodbridge, of Youngstown, Ohio, claimed before the Mahoning County Medical Society that he has been able to abort all cases of typhoid fever coming under his care before the eighth day of the disease. He claimed that typhoid fever can invariably be cured when proper treatment is instituted at a sufficiently early period.

If the treatment (outlined in a very imperfect way by the doctor), merits the attention of the profession, we fear the dogmatic assertions of the writer will find, in time, a level much beneath their asserted value. Prescriptions Nos. 1, 2, and 3 are as below. The trend of the rationale of therapeusis set up in this "shot-gun" is that somewhere here is a specific antiseptic against a predicated typhoid germ:

No. 1.

℞
Podophyllin..... gr. i.
Hydrarg. chlor mitis..... 3i.
Guaiacol..... 3vi.
Thymol..... 3v.
Menthol..... 3i.
Sacch. alb..... 3ii.

M. In very minute doses every half hour to one hour.

No. 2.

℞
Potass acet..... 3i.
Spir. nit. dulc..... 3ss.
Aquæ dist. q. s. ad ..... 3iv.

Sig. One teaspoonful every half hour in water or lemonade.

No. 3.

℞
Eucalyptol..... 3ss.
Spir. rect ..... 3i.
Guaiacol..... 3ii.
Aquæ dist. q. s. ad..... 3iv.

Sig. One-half teaspoonful every three or four hours.

The only drug here with which we are not all familiar is guaiacol, a derivative of creasote. It is an anti-pyretic, even said to be such when applied to the skin. Da Costa very recently speaks of his experience with it:

"He finds that the reduction of fever, which in one case was from 105.4 degrees to 98.6 degrees, is not attended with marked change in the pulse, nor by cerebral disturbances. In the case mentioned, and a few others, a very great reduction was followed by a slight chill, but in one instance, in which the temperature was brought down to 97 degrees, there were present no effects upon the pulse, respiration or nervous system and no chill. The reduction of temperature was most striking in cases of typhoid fever. In pneumonia of a severe inflammatory type, the reduction was comparatively slight, except about the time of the crisis, when a natural reduction would occur.

"As compared with that of the cold bath, the effect of guaiacol is produced more slowly, but is decidedly more lasting. Thus in a case of typhoid fever, the application had to be repeated but 16 times in 7 days.

"The proper dose to be employed will rarely be over thirty minims; excessive reduction of temperature followed the use of forty drops. It is to be painted or rubbed upon the skin which has first been prepared by washing with soap and water. It may be rubbed in slowly with the hand, taking five minutes for the purpose, and the surface then covered with lint or waxed paper. With a temperature of 103 degrees, it would be proper not to use more than twenty minims at the first trial.

"The chief objection to it thus far discovered, is its odor, which DaCosta has found to be best overcome by use of the oil of cloves.

"In private practice, the efficient use of the cold bath is often difficult or impossible, and it may be that here the external use of guaiacol will possess advantages that will give it a wide application."

### Vomiting of Pregnancy.

When a physician has a very stubborn case of the above nature—a case that will not yielded to anything that he has tried—patient of a nervous and excitable temperament—cannot retain even a sip of tea or water—and fast growing into an alarming condition—please try the following promptly, and if the second dose fails to give relief, then I shall write no more; it has never failed in my hands, when ever other known remedy has:

℞
Fld. ext. valerian,..... 3i.
Fowler's sol. arsenic,..... mxvj.
Sodii bicarbonas..... 3i.

M. Sig.—Teaspoonful every two or three hours.

The second dose usually relieves, and your patient will feel grateful indeed. Of course, all are familiar with these drugs, but the above combination is recent with me, and it has done what all known remedies have failed to do in my hands. Small doses of the valerian aggravate the nausea, while large ones quiet the whole system.—Julian Berry, M. D., in *Memphis Medical Monthly.*

### Therapeutics of Phenacetine.

Dr. James T. Whittaker, Professor of Theory and Practice of Medicine, Medical College of Ohio, in his recent popular text-book on medicine, discussing the treatment of influenza, says: "The pain is best relieved by broken doses of Dover's powders, or in the presence of much nausea by phenacetine. Phenacetine may be given in a single dose of ten grains to secure a peaceful sleep." In measles he states that, "Any case of fever above 103° is best controlled by warm baths which may be gradually cooled, or by occasional administration of phenacetine, gr. iii-v, more especially in the relief of the

associated nervous symptoms." In scarlatina he prefers to reduce fever by cold, tepid or warm baths, or ablutions, but if as sometimes happens, it is necessary to resort to the use of antipyretics, he recommends phenacetine as the least injurious." It may be given to a child in a dose of iiss-5 grains, to an adult in double this dose, once or twice in the course of a day. It is of especial value in headache or other nervous distress. It is best administered in capsule or in powder taken directly upon the tongue, stirred—that is, suspended—in milk, or in case of high fever with dry tongue, floated upon the surface of a teaspoon of water." While an adherent of the cold bath treatment in typhoid fever, Dr. Whittaker recognizes the fact that it is sometimes impracticable and impossible. Speaking of the use of chemical agents for reducing fever in this disease, he says that, "the safest of the modern antipyretics is phenacetine, which is best given in a large dose, three grains to a child, five grains in adolescence, ten grains to an adult, at the height of the temperature, which it will reduce in the course of fifteen or twenty minutes, a degree or two with some slight sweating, which in turn aids in sustaining the antipyresis." Dr. A. A. Stevens, in his "Manual of Therapeutics" recently published, sums up his experience with phenacetine as follows: "It may be used to lower temperature in diseases associated with higher fever, such as typhoid fever, scarlet fever, rheumatism and pneumonia. As an analgesic it is an extremely valuable remedy in neuralgia, headache, migraine, influenza, rheumatism and the crises of locomotor ataxia. It has been used with success as an antispasmodic in whooping cough."—*The Medical Fortnightly.*

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### The Reciprocal Relations of Mitral Stenosis and Pregnancy.

In the April issue of the *Univ. Med. Mag.*, Dr. Herman B. Allyn publishes a very profitable article with the above caption and relates ten very interesting cases of heart disease complicating pegnancy, or pegnancy complicating heart disease. The subject of the paper, he explains, is the reciprocal relations of mitral stenosis and pregnancy—that is to say, on the one hand, the effect of pregnancy upon the heart lesion, and, secondarily, upon the patient in general; and on the other hand, the effect which the heart lesion exerts upon the course of pregnancy and, secondarily, the effect upon the fœtus.

This is brought out admirably by his reports of cases.

Coughs, dyspnœa and pulmonary congestion, with bronchitis are the most common symptoms of mitral stenosis in pregnancy. They appear after the fourth month and increase in intensity as pregnancy advances.

General œdema is not a common symptom. It occurs only in advanced stages of severe cases.

Albuminuria also is rare.

Convulsions or unconsciousness, occurred in six cases.

Cardiac pain, at times amounting to severe angina, occurred in six cases. Palsies apparently embolic in origin occurred in three cases.

His special point in the treatment is bloodletting, preferably by venesection. His indications for it are increase in the engorgement of the lungs or heart, or when constant orthopnœa, cyanosis, edema of the feet and legs, an irregular pulse and weak second pulmonary heart sound developes.

There is no doubt as to the great value of blood-letting in suitable cases. It relieves the engorged right heart, and by lessening the volume of blood upon which it must contract, permits of compensatory hypertrophy. The value of loss of blood is shown practically by the statistics already quoted—hemorrhage in some form occurring in 18 of the 37 favorable cases and in only eight of the fatal cases.

The puerperium should be closely watched and the patient prevented from rising or doing anything to cause overdistension of the dilated and weakened right auricle and ventricle.—*Ft. Wayne Med. Mag.*

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### Habitual Headache as a Prominent Symptom of Some Nasal Diseases.

Dr. Scheinmann makes the statement that most nasal diseases are accompanied by more or less headache, in many instances the headache becoming habitual. In both neurasthenic and hysterical persons, local examination of the nose should not be forgotten, as oftentimes the seat of the trouble is entirely within the nares. Headache is sometimes the only symptom of a diseased nose or accessory cavity, and by cure of the nasal disease the headache vanishes. In neurasthenic persons cocainization of the diseased parts will oftentimes cause a disappearance of the headache. One of the most frequent causes of headache (from nasal disorder) is hypertrophic swelling of the turbinateds, though the observations of the author prove that empyema of the antrum of Highmore, even combined with phlegmon of the orbit may be only indicated by headache. Cure of the empyama removes the headache. The author has found that carious gummatous processes, crests and spines of the nasal septum, and oftentimes lesions that seem quite unimportant, may be the cause of violent headaches, as proven by cases coming to his notice. He concludes by saying that in all cases of headache it is important that the nose should be thoroughly examined.—*Berliner Klin. Woch.*

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### Mucous Disease.

This is a very frequent disease of children, and is most common between 3 or 4 and 10 years of age. It consists of an increased secretion of mucous from the internal surface of the alimentary tract, which interfers mechanically with digestion and absorption of food, and by its influence in impeding nutrition, often excites suspicion of the existence of tubercle.

The symptoms are slight at first, and become more severe as the disease advances in

its course. The child is dull; disinclined to exercise, and complains of weariness. He becomes pale; loses flesh; his spirits are low; takes no pleasure in amusements, and is listless; sometimes crying without cause. He is drowsy during the day, and restless at night; his sleep often being disturbed by frightful dreams. Sometimes he arises from bed while asleep, and walks from room to room. Nocturnal incontinence of urine is frequently complained of. The appetite is capricious, and each meal is followed by flatulence and uneasiness. The appetite may remain good; sometimes the hunger cannot be satisfied.

The tongue is flabby and indented by the teeth, and has a glossy, shiny look, as if it had been brushed with mucilage.

The bowels are either constipated, or move frequently and scantily, and the stools contain large quantities of mucus.

The complexion is often jaundiced. The skin becomes rough and harsh.

The glands of the neck are liable to become enlarged on irritation.

The temperature of the body is seldom elevated above normal.

Worms form a frequent complication of this derangement.

*Treatment:*—Pay strict attention to the diet. Farinaceous foods must be forbidden, and the child nourished on meat, eggs and milk. Regulate the amount of food taken at each meal, and have them often.

At night bathe patient with hot water, and after drying rub in oil.—*Extract.*

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### Ice in Phlegmasia Alba Dolens.

Dr. John A. Miller (*Pacific Med. Journal*), in treating on the subject of "milk leg," speaks highly of the efficacy of the cold treatment of the disease. He first used it in 1886, and since then has used it in six cases with uniform and decided success. The procedure was in the following manner. An ordinary large towel was dipped into iced water, wrung out and clapped around the affected limb; a heavy flannel roller bandage was then applied from the toes upward to the groin. On the most painful parts, like the inner aspect of the thigh, the popliteal region and the calf of the leg, were laid rubber bags filled with ice. These were kept in place by a circular binder, independent and outside of the roller bandage. The patient was a little shocked when the cold towel was first applied, but the unpleasantness was only momentary, and then the reaction brought ease and comfort. She desired the ice bags to be renewed quite often at first, as she claimed they relieved the pain, as anything else had never done before. The pain was entirely controlled by the cold. The temperature dropped from 103° to 100° the next day, and the patient commenced to improve, which continued uninterruptedly. The towel was freshly dipped from four to six times in the twenty-four hours. As soon as the patient experienced relief, she was quite anxious to endure the temporary chill from a fresh compress, because the limb felt always better for it afterward. The towels soon became dry and hot, and this gave rise to painful symptoms again.—*St. Louis Medical and Surgical Journal.*

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### Period of Infection.

The period of infectiousness of contagious diseases, according to the State Health Board of Pennsylvania is:

Small-pox.—Six weeks from the commencement of disease, if every scab has fallen off.

Chicken-pox.—Three weeks from the commencement of the disease, if every scab has fallen off.

Scarlet-fever.—Six weeks from the commencement of the disease, if the pealing has ceased and there is no sore nose.

Diphtheria.—Six weeks from the commencement of the disease, if sore throat and other signs of the disease have disappeared.

Measles.—Three weeks from the commencement of the disease, if all rash and cough has ceased.

Mumps.—Three weeks from the commencement of the disease, if all swelling has subsided.

Typhus.—Four weeks from the commencement of the disease, if strength is re-established.

Typhoid.—Six weeks from the commencement of the disease, if strength is re-established.

Whooping-cough.—Six weeks from the commencement of the disease, if all cough has ceased.

Under judicious treatment the period of infectiousness may be considerably shortened, but no child suffering as above should be admitted to any school after a shorter absence, and then should be provided with a medical certificate that he or she is not liable to communicate the disease.

Length of Quarantine.—Teachers or children who have been exposed to infection from any of the following diseases may safely be re-admitted to the school, if they remain in good health (and have taken proper means for disinfection) after the following periods of quarantine:

Diphtheria, 12 days; scarlet fever, 14 days; small-pox, 18 days; measles, 18 days; chicken-pox, 18 days; mumps, 24 days; whooping-cough, 21 days.

Adults may be re-admitted immediotely, if they disinfect their clothes and persons.

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### Olive Oil and Chloroform for Gall-stones.

It is now generally understood that olive oil taken in large quantities is a useful remedy for facilitating the passage of gall-stones through the common duct into the intestine. Numerous cases have been reported in which this remedy has succeeded. In some cases, doubtless, the round, greenish colored masses which may be found in the stools of a patient who has taken considerable quantities of olive oil, may be mistaken for gallstones by one who is inexperienced in detecting these calculi; but a sufficient number of well-authenticated cases in which actual calculi have been observed, have been recorded to

give the remedy a standing sufficient to make it worthy of trial. The efficiency of the remedy may be greatly increased by simultaneously administering chloroform in medicinal doses. Opium is to be avoided in these cases, for while it relieves the pain, it at the same time increases constriction of the duct, whereas chloroform both relieves the pain and relaxes the involuntary muscular fibers of the duct, thus facilitating the passage of the calculi.—*Modern Medicine.*

### Antiseptic Mouth-Wash.

In his "Treatise on Disease of the Mouth" E. Maurel gives the following formula:—

℞ Alcohol of 850 degrees.....3ij.
Tincture of eucalyptus.....3v.
Tincture of cinnamon.....3iiss.
Tincture of rosemary.....3i¼.

M. Sig.: A teaspoonful to a glass of warm water.

### Treatment on Enteric Fever.

Maillart (*Rev. de. Med.*, November, 1873.) begins a study of cases of enteric fever treated by the internal administration of large quantities of water. The first object of treatment is to destroy the micro-organism, but failing this the action of their products must be neutralized. These toxalbumins are excreted by the kidneys. In enteric fever the urine is diminished in quantity, and the skin does not act, hence the object should be to encourage these emunctories. In order that a large quantity of water should be excreted, a large quantity must be provided. Subcutaneous infusion may be adopted if the patient is unconcious, or in severe hemorrhage. Water can also be supplied by rectal injections, but the simplest way is to make the patient drink copiously. The author endeavors to ascertain the effect of this treatment on the different symptoms in fourteen cases of enteric fever minutely studied. Only one case died. The patients take to this treatment readily. Exceptionally as much as 16 litres were taken in the day. The mouth became moist, and the trouble in swallowing owing to dryness of the pharynx disappeared. Thus antisepsis of the mouth is more easily effected. The stomach tolerates this treatment; in exceptional cases vomiting occurred at first, but this soon ceased. The water was excreted by the kidneys and skin, the quantity of urine being greatly increased.—*M. A. Practitioner.*

## HYGIENE.

### Water Purification by the Alum Method.

It has long been known that addition of small quantities of alum to impure water has the effect to cause the precipitation of its impurities, and this method has been used, sometimes on a large scale, as a means of purifying water. Max Teich, of the Institute of Hygiene of Vienna, has recently made a study of the value of this method, and finds that while the method offers no objection from a sanitary standpoint, and is capable of killing cholera germs, typhoid fever germs are not materially affected by it, and treatment of the water for at least twenty-four hours is necessary to destroy the germs of cholera.—*Modern Medicine.*

## OBSTETRICS.

### The Conduct of Ordinary Labor Through External Examination Solely.

Leopold and Sporlin (*Archiv f. Gynakologie; Med. News*) make a warm plea for limiting examinations made in the course of ordinary labor to the external parts, and the advantages of such a course. Infection is thereby avoided; the natural sense of modesty of the parturient is not offended; and careless rupture of the membranes is avoided. Skill in external examination is acquired with reasonable readiness. In the large majority of cases such examination alone is sufficient for the recognition of the position and presentation of the fetus, and for the study of the course of an ordinary labor. As there can be no objection to its frequent exercise, abnormalities of paturition may the more readily be detected early, and means of correction promptly employed. Experience soon teaches the difference in the position of the fetus assumed in case of pelvic contraction on the part of the mother. The position and presentation having been recognized by external examination for the determination of possible pathologic conditions of the birth-canal need be but brief, and can be conducted with great care. For the attainment of this desirable result it is essential that the obstetric pupil familiarize himself thoroughly with the conditions of normal labor as determined by physical external examination, as well as with the physiology of normal labor. Obstetric operations are principally to be taught upon the phantom.

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# ORIGINAL ARTICLES.

## CONTRIBUTIONS TO OBSTETRICS AND DISEASES OF WOMEN.*

[NUMBER ONE.]

THEOPHILUS PARVIN, M. D., Philadelphia.

Preliminary Remarks.—In presenting the readers of The Medical and Surgical Reporter with the first of a series of papers under the above title, a few prefatory observations are made, more especially concerning the purpose and the plan of these contributions.

One of the acutest observers and most vigorous reasoners of the century, the late Archbishop Whateley, once remarked: "Some people speak because they have something to say, and others because they want to say something." The writer trusts he has something to say—something that may possibly prove useful to some readers—he would be silent rather than speak from the desire to say something.

The papers will be chiefly clinical, and thus the report of a case or of cases will be presented, and this followed by reflections, imitating the method employed by that able French obstetrician, La Motte, whose great work, published nearly two hundred years ago, has hardly been equalled as a contribution to clinical obstetrics. Occasionally a subject belonging to obstetrics or diseases of women will be discussed, without any clinical observations.

I shall not refrain from narrating some of my own errors when there is hope such narration may haply enable others to avoid similar transgression. Lord Bacon wisely said, "men mark when they hit, but never when they miss." And is not this often true in medicine, especially in its surgical department? We frequently read of brilliant operations, only rarely, if at all, of black failures by the same operators. So, too, there is a tendency to proclaim the errors of others, and to conceal our own, in this respect possibly even proving that the statement made by the Marquise of Queensberry, the famous "Kitty" of Prior, in a letter to Dean Swift, is not exclusively true of women: "Most women have an inconceivable pleasure to find out any faults, except their own." None of us is so wise in diagnosis, and so skillful in treatment that he never makes a blunder; infallibility belongs no more to doctors than to other human beings, and they who seem to claim it, harshly judging their fellow practitioners, constantly and publicly proclaiming their own greatness and success, may be temporarily enthroned as golden gods, but will by-and-by prove upon close examination only gilded clay

* [This series of short papers is contributed by special request of The Reporter. The preliminary remarks indicate the scope of the series. The name of the writer is sufficient guarantee for the value of the observations recorded.—Ed.]

or polished brass; their example is evil, and their work is of no permanent good to society or to the profession.

A few words more: The pompous, and, so far as etymology is concerned, the perverted word gynecology will be ignored in these papers, and so, too, its derivatives. Our literature is becoming loaded with needless neologisms, and many a doctor frankly confesses that he fails to understand some writers, unless while reading their articles he has at his elbow the most recent medical dictionary.

So, too, Zolaism will be given no place. The reaction in general literature against the naturalism of Zola has begun, and so, too, similar reaction will come in medical literature. Illustrations are given in text-books, in medical journals, and advertisements addressed the profession, both at home and abroad, needless nudities of the female form and sexual organs, and descriptions and discussions* in regard of subjects which neither exalt nor instruct, do not help in the diagnosis nor in the cure of disease, and invite pruriency rather than purity of thought, aversion more than approval. No one could imagine that Sir James Y. Simpson or Hugh L. Hodge would utter what is now spoken by some of their successors, or permit in their volumes such illustrations as we now sometimes see in works on diseases of women. Those of us who thus transgress will find no pleasure in the retrospect of our transgressions, conscious that we have thereby not increased but lessened "the sweetness and light" of professional life.

After forty-two years spent in practice, nearly three-fourths of those years engaged also in medical teaching, it is quite possible I will at times express opinions differing from those that are prevalent to-day; but a doctor ought to cultivate catholicity of creed, hoping thus possibly at least, to reconcile occasionally discordant views, taking from each such element of truth, great or small it contains, abhorring that dogmatism which too often is manifested in professional beliefs and practice. Positiveness of assertion and obstinacy of belief may arise from imperfect knowledge, and looking at a question in one part, or from the limits, the small window of personal experience, ignoring what others see from their windows. Occasionally one is tempted by the medical dogmatist to repeat to himself the question of Montaigne, "is there anything so assured, resolute, disdainful, contemplative, serious, and grave as the ass?"

But I conclude these introductory observations, which may seem to some too discursive, but which have not been without design, that possibly other readers may see and appreciate.

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### ATRESIA OF THE UTERUS IN LABOR.

The patient was seen in consultation with Dr. P. H. Markley, of Hatboro, Penna., and I first present the Doctor's history of the case before my visit: "Was called to see Mrs. L., primigravida, January 19, 1894, in the evening. She was apparently in the first stage of labor, nothing unusual having occurred during her pregnancy. Making a vaginal examination, much to my surprise I could find no os uteri, nor the slightest indication of where it should be. Thinking that possibly the pains might be false, I directed a rectal injection, and used hypodermically one-fourth of a grain of morphia. The pains were not set aside, but rather intensified. I repeated my vaginal examination, the labor having been in progress some hours, but after the most careful search could find no trace of an os. I felt satisfied that there was complete occlusion of the uterus, and sent for Professor Parvin."

It was impossible for me to immediately answer the call, and the second night had come before I reached the patient's residence, some fifteen miles from the city. I found a strong, healthy woman in active labor, the severity of her suffering being mitigated by the inhalation of ether. While she was brought more completely under the influence of the anæsthetic, I made a careful vaginal examination. The head was in the pelvis, making a large hemisphere, to which the uterine wall was closely applied, but nowhere could the os be discovered; this examination was made first, the patient lying upon her back, then upon her right, finally upon her left side; the entire hand was introduced into the vagina, the right hand when she was upon her left side, and the left when she was on

* Whenever such references are pertinent they are proper; but when impertinent they are impudent. The reader will here observe I am using the adjectives in their etymologic sense.

her right side; every square inch of the hemisphere was deliberately and carefully explored, but I could learn nothing more than my friend had done. If it had been daylight, and if a suitable speculum had been at hand, of course it would have been our duty to ascertain if the eye could tell us what the fingers failed to do; but a poor artificial light, and no speculum of any sort rendered impossible such exploration. Again examining with the finger, I thought I discovered a very slight and small elevation, comparing a little thing with great, a sort of cliff overhanging and hiding the entrance to a cave; the position corresponded with that which the os would normally occupy. This conclusion having been reached, I first endeavored by gentle pressure with a silver female catheter, then with a director, finally, with a probe to make an opening into the uterus—of course, severe or strong pressure while effecting a perforation of the uterus, would have almost inevitably done more or less serious injury to the child's head; the instruments available were by no means many, or best—I had known nothing of the nature of the difficulty before my arrival. There was now but one thing to do when penetrating with a blunt instrument seemed impossible, or dangerous, and that was to cut the obstructing tissue; accordingly a small pair of scissors held in one hand, the points guided by two fingers of the other hand to the slight elevation found upon the uterine surface which has been mentioned, and then the tissues were carefully snipped through, the incision permitting the introduction of a silver catheter. The catheter was used to stretch the opening, then a finger was introduced, and soon two or three were employed to dilate the os. In the course of half an hour the os was completely dilated, or dilatable. Wallace's forceps was applied by Dr. Markley, and a large, living, uninjured child was delivered, considerable force being required for the extraction. A hot water antiseptic injection of the uterus was made after the delivery of the placenta; nevertheless there was considerable hemorrhage, so that compression of the uterus and the administration of ergot were necessary. In a few hours reaction was satisfactory, and I returned home. Forty-eight hours subsequently I was sent for on account of a chill followed by a temperature of 103.° I found the lochial discharge offensive, and washed out the uterus very freely with creolin mixture in hot water. The fever soon declined and disappeared. Subsequently the patient's convalescence was neither interrupted nor delayed, except by a slight attack of *phlegmasia alba dolens*. Dr. Markley has recently informed me that both patient and child are quite well; the uterus has somewhat greater than normal length, and the cervix was apparently torn.

REFLECTIONS.—Complete, spontaneous atresia of the os uteri observed in labor is very rare, so rare that some obstetricians deny its occurrence, while most admit atresia may result from cauterization. Delore* refers to the observations of Dubois and Depaul as proving beyond doubt that spontaneous obliteration of the cervix may occur. He also narrates the following case observed by him: The patient was forty-two years old, a primipara, and had not had any anterior lesion. She was exhausted by several hours in vain efforts. At the fundus of the vagina with speculum and finger it was impossible to find the least trace of the orifice, or of projection of the neck. A crucial incision was made, and the labor progressing slowly, the forceps were used. Martin,† on the other hand denies atresia, and explains the alleged instances as simply those of stenosis, this being so great in some cases that only a sound as fine as a hair can penetrate the opening, and yet permitting the escape of fluid from the uterine cavity. In considering the diagnosis Martin, after referring to the exposure of the vaginal vault with the speculum, and seeing upon a round mass, pressed downward, a smooth shining, stretched, bluish-red surface, where one observes upon one side, when not in the median line, a pin-head opening, or the radiating white glistening cicatrix, adds that the membranes, as a rule, rupture from the energetic contractions of the uterus, the amnial liquid escaping and there can be seen, especially during a uterine contraction, a fine stream pass from the opening. The last point, which I do not remember to have found in any other work upon obstetrics, seems to me of considerable importance in distinguishing between atresia and stenosis; of course, too, when one sees this stream, he not only makes a certain diagnosis, but also at once

* Traite Pratique de l'Art des Accouchements.
†Lehrbuch der Geburtshilfe von Dr. A. Martin, 1891.

knows where the orifice is. My friend, Dr. Markley, in talking with me over the case, asked me when the membranes ruptured, and I could not answer his question. Therefore, in reflecting upon the matter, I do not think it impossible, in view of Dr. Martin's statement, that the os might not have been impervious, though by all the means that were available to Dr. Markley and myself, it was impossible to come to any other conclusion than that there was complete atresia, and that the amnial liquor had made slow and silent escape. Nevertheless, it would be advisable in a similar case to carefully examine by sight for fluid coming from the uterus, when such examination can be made before making a positive diagnosis.

In the tenth edition of Schroeders' *Geburtshulfe* edited by Olshausen and Veit, 1888, reference is made to the closure of the mouth of the uterus occurring in pregnancy, this atresia sometimes being the consequence of cauterization. In the most recent German work upon obstetrics, that of Kaltenbach, 1893, stenosis, but not atresia, originating in pregnancy, is described. This author, as others have done, refers to the imminent and unavoidable rupture of the thinned cervical wall rather than the yielding of the stenosed os, if suitable obstetric help fails.

The directions for the treatment of this atresia given by Winckel, (*Lehrbuch der Gérburtshülfe*, second edition, 1893) in case perforation cannot be effected with finger or sound, are to expose the part in the vicinity of the mouth of the womb with a duckbill speculum, after first disinfecting with four per cent. carbolic acid solution, when the tissue is held by tenacula, and either with or without previously pencilling with a four per cent. solution of cocaine, a superficial crucial incision is made through the membrane, and followed by, perhaps, excision of the four ends of the flaps these produced. He employs a vaginal injection immediately afterward, of a three per cent. carbolic acid solution.

But without further consideration of the disputed question as to atresia of the os originating during pregnancy, the obstetrician in making a diagnosis should bear in mind the possibility of sacciform dilatation of the posterior wall of the uterus, and mistaking it for atresia, as in the case reported by Depaul.* This error is impossible if the anterior vaginal vault is accessible, and is carefully explored.

## CONTAGIOUSNESS OF TUBERCULOSIS.†

J. C. SPRAE, M.D., Norristown, Pa.

Whether or not tuberculosis is contagious is not a new question, though 'til very lately it has not attracted much attention. About one hundred years ago, in Naples, compulsory registration of those ill of phthisis, and the destruction of the bedding, furniture, etc., after death, was rigorously enforced by law, and this was the practice until forty years ago. I have myself known Americans in Italy and the south of France, put to much expense and trouble by claims arising out of this idea which still lingered in the minds of the ignorant, though the law was repealed as early as 1855.

The evidence is positive that this way of dealing with phthisis in Naples neither lessened the number of cases, nor in any way benefited the city.

About the year 1870, Dr. L. F. Flick began his painstaking investigations in the Fifth ward of Philadelphia, and soon announced his belief that tuberculosis was contagious, and that the house of the sufferer was the special centre of infection. But his reports being at variance with the observations of medical men in general, were not seriously considered.

With the discovery of the tubercle bacillus, in 1880, bacteriologists and pathologists were able to demonstrate the infectious nature of this disease by the inoculation of animals, and in the course of the past year a number of American societies, among them the Philadelphia County Medical Society, passed resolutions declaring the disease contagious, and recom-

*Archives de Toclogia, 1876.

† Read before the Montgomery County Medical Society, May 9, 1894.

mending all cases to be registered by Boards of Health.

Dr. J. S. Billings, the collator of the medical statistics of the census for 1890, estimates there are about six thousand cases of consumption in Philadelphia, and on the basis of relative population Montgomery county would have eight hundred cases and Norristown one hundred and thirty. By the same method of reckoning there are in the United States about half a million cases of consumption. I take it these figures do not include surgical tuberculosis.

Anything affecting the liberty or personality of this large number of citizens is naturally a matter of importance. The strongest, and indeed the only considerable evidence presented by the contagionists, is the fact that the disease is reproduced in animals by inoculating them with the tubercle bacillus. It is found that the reproduction of the disease by inoculation, even in the most susceptible animal, the guinea-pig, is by no means certain and easy; and that the growth of this bacillus, even in specially prepared culture media, is more or less difficult; that slight variations of temperature, dryness of the atmosphere, and the presence of other organisms, each or any of them kills the tubercle bacillus. I go into these bacteriological details to show how unfair is the inference that when there is proof of contagion by inoculation, it necessarily follows there will be contagion from person to person in the ordinary course of daily life. We know of several diseases that are most certainly reproduced by inoculation that as a matter of fact never, or but very rarely spread in the ordinary intercourse of mankind. Syphilis may be cited as one of these.

To my mind the strongest evidence of the noncontagion (I mean in the ordinary sense of that word) of phthisis is the fact that practicing physicians attending thousands of cases for months and years have failed to note this feature in their consumptive cases. They certainly are better witnesses in this matter than the bacteriologist who perhaps has never followed a single case of this disease through its course in the family. It is true that now and then there is a second case in the same house, probably after a long interval, and this is easily accounted for by the general prevalence of the disease. It is claimed that since attention has been directed to the destruction of the sputum, phthisis has measurably diminished in some of the great cities of the world; but this, I take it, is amply accounted for by better sanitation in these centers of population, as practiced in the last ten years especially.

The medical history of all the resident physicians in the Pennsylvania Hospital for seventy years furnishes most conclusive proof. There are 147 of these gentlemen, only one of whom died of consumption, and he not for five years after leaving the Hospital; and, further, he was in poor health before he became a resident. Remember, too, sixty years of this time was a period when no attention whatever was paid to the destruction of the sputum of the many cases of phthisis constantly found in the wards; and also when no one thought for a moment that consumption could be in any degree contagious. And besides, all these young physicians were passing through the most susceptible period of their lives with respect to this disease. This history is certainly most interesting and important. Contrast the statistics supplied by these one hundred and forty-seven young men with that of a similar number of students in any one of our colleges where they are not specially brought in contact with this disease, and the record of immunity could not possibly be better. And where the same number are employed in unsanitary work-shops, I am sure many would certainly become consumptive.

Contagious diseases have a well-marked period of incubation, but phthisis has not, except in the case of animals infected by inoculation. A herd of previously healthy cattle becomes infected with tuberculosis. There has been no inhalation of dried sputum in all probability; the herd indeed has been confined within known limits, such complete isolation as would be for mankind the strictest quarantine, and yet tuberculosis has effected an entrance. A recent writer cites the peculiar anatomical safeguards, or sentinels, of the breathing apparatus of man, by which he is able to exclude, in so many instances, the tubercle bacillus, and thus endeavors to account, in part, how it is so many persons escape. He forgets that the same breathing apparatus is quite powerless to stay the entrance

of really contagious germs, as in small-pox, where one whiff is followed most certainly by the disease in fourteen days. It is, doubtless, the absence of conditions favorable to the growth in the lung of the tubercle bacillus that insures our safety. If consumption were really so contagious as some would have us believe, the hotels at Lakewood, Fortress Monroe and St. Augustine would be pest houses, and Cairo, Algiers and Nice would be plague spots, and the latter city most of all, because it was a famous winter health resort for the Romans as early as the days of the Empire.

Many of us will recall how some ten years ago a few sanitary enthusiasts advocated compulsory cremation as a sanitary necessity, and declared war on all cemeteries. Indeed, I well remember how this proposition very near came to passing the American Medical Association, in 1886, at St. Louis. About the same time we had the syphilis fright, and public drinking cups, barber-shops, door knobs and the like were all declared highly dangerous.

Registration of tuberculosis as a contagious disease means for the registered ones and their families surveillance, publicity and oftentimes the painful necessity of violating confidences by the attending physician. It further means inhibition as to attendance at school and church and other untold hardships to the sick. It would give the consumptive the feeling that he was officially declared a disease-spreading person, and the consequent worriment, with all hope cut off, would surely defeat the best efforts of the physician at amelioration or cure. The sick would first be shunned and then neglected. Practicing physicians of experience know of their own personal knowledge that the facts do not warrant the State in imposing these hardships on this class already overweighted by misfortune. We can do much good, I am sure, by assuring these sufferers of our sympathy and protection, and by holding out to them, or at least some of them, the undoubted promise of restored health by reason of modern therapeutics and curative climate.

## CELLULAR RADIATION.

G. P. HACHENBERG, M. D., Austin, Texas.

An accident met with recently has induced me to communicate this paper.

In stepping out of a phaeton I struck my left hand against the edge of an iron rod. I had on at the time a pair of heavy kid gloves. The blow made no rent in the glove, but caused an abrasion of the skin on the outside of the hand, about three-quarters of an inch in diameter. For a few hours the wound pained me very much, causing considerable constitutional disturbance. The next morning I was sick with *la Grippe*, but my wound was painless. In the afternoon I noticed a radiation of delicate straight lines surrounding it, extending from one to two inches from the wound, about one-eighth of an inch apart, slightly bulbous at their connection with the wound, and at the periphery of the radiation, so fine that they hardly could be seen. The color of these lines was the same as the skin of the hand, with no appearance of inflammation. The lines were only seen when the hand was in a state of flexion.

I gave the wound no special treatment, but left a layer of blood on it to dry, to exclude it from exposure to the air. The radiation daily diminished in size from the circumference, and had almost disappeared, in about ten days, or rather within the "age of resolution," leaving a greatly diminished size of the wound in form of a scab. When the scab was removed, the cicatrix followed by a dry process, leaving a slight trace of the radiation, and its connecting vascularity.

What is the nature of this radiation, and what is its function? The lines were geometrically straight, and could not be vascular in nature; but evidently were of a intercellular material, developed under fixed laws of its own. The radiation was caused by a traumatic irritant. Although its lines were seen but on the surface, there is no doubt they existed and radiated in the same manner from the wound into the surrounding deep tissues. In the case of a wound deeply imbedded within the body, as a gun shot wound, such a

lineal cellular organization would surround it from all points.

The formative process of these lines is primarily effected by the wound itself. The traumatic irritation caused a contractility of the connective cellular tissue, aiding the migration of the intercellular cells to the raw surface of the wound, where their energy became augmented by a vital affinity with the fibrine exudation from the local congestion. This affinity now established transmitted its vital influence in a direct line to the rear cells, forming the lines in question. The immediate cells thus forced by its own innate power, to the wound pass through a transformation, as it surrenders its blastema to the inflammatory exudation in the formation of granulation. When the granulation, or rather the metamorphasis into exudative cells is about completed, the radiation diminishes, and it is the peripheral portion of the lines that first disappear.

But what becomes of the last issue of these lineal cells, after the wound is healed, and they are no longer in demand? It appears when cells forming these lines are no longer needed, they having not the power to recede into their native locality, are changed into connective cells, they lose their shape, size, color, elasticity and power of propagation. It appears here lies the secret, why when any part of the body has been seriously damaged by a wound or by a disease, it has not the same recuperative power it had before; and it even accounts for the predisposition of the same disease that existed once before. As the ultimate locus of life is in the cells (which we know by the primordial cell, and its power of propagation), it is when these are impaired we find the cause of decay in old age, and the remote cause of disease by fault of assimilation and nutrition.

The physiology of cellular radiation, in connection with wounds, has some very interesting features. Its reciprocal action with the wound itself regulates and builds up the healing process. If the traumatic inflammation is, so to speak, within physiological bounds, we have what we call union by first intention. But when the balance of this reciprocity does not exist, we have ulceration, fungus growth, or even gangrene. The contractility of the connective cellular tissue and the mobility of the intercellular cells gives a prompt response to the irritation of the wound. It appears to be an independent reflex action from the wound itself, and is not connected with any muscular structure, and is even without nerves.

Cellular radiation only assumes a pathological feature when subserving to some existing disease. I have my doubts if it is ever etiological in its primary action. It is on this very point we find Virchow and Rokitansky's cellular pathology not tenable. Cells not connected with vascularity have no pathology. The former made a significant remark in regard to the individuality of intercellular cells, from which we draw the inference, that they are not etiological of disease, but may be readily destroyed by a high inflammatory action. He says: "Every individual cell may run its own peculiar course, may undergo its own peculiar changes, without the fate of the cell lying next it being necessarily linked with its own." The intercellular cells have a system of their own; in many of their functions they are independent of the connective tissues, and the nervous and vascular systems. They have an intimate relation with the capilliary circulation, not by a direct communication, yet still in a way to become the recipient of blastema by endosmosis. It is true that a parent cell may have its anomalous development, but that would not come within the range of our consideration.

Nearly all topical medical treatment has its effect on cellular radiation. For ages local remedies were administered with the view to control nervous and vascular action, when often, in a direct manner, they had but little to do with either.

I will briefly refer to a few cases in my own practice to verify this statement:

1. In amputating a finger, I dipped the stump into the spirits of turpentine before applying the dressing. A healing of the first intention followed. Modern surgery would ascribe this ready healing to the antiseptic properties of the remedy. This, however, was not the case; for it was the application of turpentine that aroused the energies of the cells, in a way to favor the formative process.

2. In the summer of 1866, I operated on a maiden lady of great obesity, to relieve her of strangulated inguinal hernia. The operation gave her immediate relief; but the depth of the wound, the hot

weather, and the plethoric condition of the patient gave me considerable uneasiness as to the prognosis of the case. I closed up both the ring and the external opening with sutures, and as a prophylactic to pyemia and gangrene, kept a compress over the wound saturated with a weak solution of Labarrque's solution. The wound healed rapidly with very little suppuration. Then I could not fully account for the speedy recovery of my patient. It is true I gave credit to the antiseptic treatment and the recuperative powers of nature, but there was an auxiliary that favored the recovery I could not account for, for I remember not a drop of the solution, for obvious reasons, was allowed to enter the wound itself. In my retrospection of the case now, I see how Labarrque's solution stimulated cellular radiation, and no doubt favored the rapid recovery of my patient.

3. In the late war having in charge a hospital, one evening a soldier was brought in with double pneumonia. He labored under great dyspnœa, cyanosis, and other unfavorable symptoms. He was put to bed, and I ordered a large compress saturated with spirit of turpentine to be applied to his entire chest, to be left on all night, if the turpentine were tolerated. Next morning the patient was greatly relieved, and with a general treatment that followed he finally recovered. Then I gave all credit to counter-irritation for the happy effects of the case, yet, from my present views of the case, I believe if I had blistered the man, in all probability he would have died that night. I will not stop here to give the differential therapeutic effects of the two irritants. But what did that counter-irritation effect? Was it only forcing a vascular circulation to the surface? Not at all. It transposed the pulmonic irritation to the surface, followed by arousing a full energy of the cellular radiation of the entire chest. As soon as this was effected the *recently* formed pulmonic hyperæmia was readily overcome. But had the pneumonia been in a more advanced stage, the treatment would not have saved the patient.

When an inflammation sets in, under the storm of a violent vascular action, followed with rapid infiltration, the cellular radiation immediately follows to resist (rather to repair) the morbid action; but where the inflammatory action is so much greater than the cellular resistance the latter rather increases than diminishes the inflammatory force; therefore, it may appear to become a pathological element in the disease. This question throws some light on the subject of the administration of antipyretics with good effects.

Cellular radiation as a physiological factor in the animal economy resists all diseases; but when it fails to overcome a morbid resistance it may be the means of doing great harm. It is thus in syphilis, cancer and infectious miasm it disseminates the seed of the disease throughout the body. This explains why irritating topical applications to cancerous growth, may cause cachexia, and shorten the life of the patient. Therefore to take advantage of this cellular force, we have to take into consideration what resistance it may meet, as in inflammation, tumefaction, granulation, ulceration, fungus or malignant growths, etc. When no great resistance is in the way, as in recent wounds and inflammations, its recuperative effects are readily manifested, but where they do exist they must be removed if possible to gain any advantage. For example: in recent ophthalmia a mild sedative alterative collyrium may give relief in a day or two; that is the collyrium holds the irritation and congestion at bay, whilst the cellular radiation is effecting a cure by resolution; but let the ophthalmia be of a chronic nature with obstinate painful granulations, although the cellular force is not withheld, but rather augmented, no cure is effected, but in the strugle with the inflammation, causes tumefaction of the lids, and adds to the granulation itself. Now what is indicated is the heroic treatment to break up the granulations with the knife or caustic, to make way for a resolution on the system mentioned.

The modus operandi of cellular radiation on open wounds and parenchymatous inflammation are not the same. The former is an exudative process, and the latter ends in a force of absorption. In our case of double pneumonia, the *limited continuous* irritant to the chest finally overcame the pulmonic irritation, which was the initiatory stage of inflammation, and at the time bringing a surplus of cellular force to the surface; the two adventitious forces in the lungs were now properly balanced, and resolution at once ensued.

It is not the case, as is generally supposed, that an external irritant alone will compensate for an internal congestion. Congestion before it causes organic changes, if overcome by proper means, disperses with wonderful rapidity.

The contractility of the connective cells toward the seat of the wound, has forcibly revealed itself in the following case:

4. In 1860 a teamster in a state of intoxication fell from his wagon, that was heavily loaded with brick. One of the wheels passed over his head, tearing away the integuments from the left side of the head, leaving a flap lying over the left upper side of the face. It appeared as if a large portion of the pericranium was shaved away with the flesh. I carefully cleansed the wound, and brought the flap to its place as well as I could, mainly with sutures. An inflammatory action set in, and tore out every suture I had made. I replaced them repeatedly, but noticed that the resistance of the flap became less every day as the inflammation lessened, and finally ceased entirely, and a *reverse action* set in in the closing up of the wound.

The healing of a wound is more promoted by cellular radiation than by local inflammation. A healthy local inflammation is a necessity, but mainly to resist the absorption of septic matter from the wound. This resistance is simply a blocking up of the surrounding tissues of the wound, in which cellular radiation likewise is an important factor to effect this, but is characterized by the power of exudation instead of absorption. In my "Medical Consultation Book," I paid special attention in pointing out the effects of the albuminoids in protecting the system from the internal encroachment of toxic matter. The subject is one of great interest, and now to add another order of protection in the healing process of wounds, makes the study of self-protection in the animal economy a most interesting subject to the surgeon and the physician.

# COMMUNICATIONS.

## THE PRESIDENT'S ADDRESS.*

[ABSTRACT.]

JAMES F. HIBBERD, M.D., LL.D., RICHMOND, IND.

After thanking the Association for having conferred upon him the honor of presiding over its deliberations, and referring to the beautiful scenery and the scientific menu of the program, Dr. Hibbard spoke of the change of the time of the meeting, which had been rendered desirable in order that many of the State Societies would have an opportunity to act on the question of the revision of the Code of Ethics.

At every annual meeting the officers of the Association, particularly the Permanent Secretary and the Treasurer, have difficulty in appeasing delegates who are not received because the credentials presented by them have not been issued by a society entitled to representation in the Association. The law regulating this matter is plain, to wit: "The delegates shall receive their appointment from permanently organized State Medical Societies, and such county and district Medical Societies as are recognized *by representation* in their respective State Societies." Some of the State Societies are not representative bodies, and consequently this constitutional provision cuts off all delegates from such States except those commissioned by the State Society itself. While this is the letter of the law, it is not the spirit that animates the organization of the Association. The constitution should be revised in this particular at least.

This trouble could be overcome either by a change in the constitution, or better, by a representation of every county society in its State Society. The plan of

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organization so long in successful and satisfactory operation in Indiana might serve as a paradigm. In Indiana the State Society and each county society is a legal corporation. This is not essential, but desirable. Then, every medical man ought to belong to a county or similar society, and thereby to their respective State societies, whence, for the asking, they can step through the portals of this Association, and find in the sections a department already organized into which they can enter, according to the tastes or qualifications, and where a member of any special organization will find himself in the midst of all the members of an Association whose tastes run parallel with his own, whether specialist or general practitioner.

When Dr. Geo. M. Sternberg was appointed Surgeon-General of the Army in May last, he made two innovations in the administration of the affairs of the office: 1st. In establishing an Army Medical School to give passed candidates for appointment to the Army, laboratory practice in bacteriology, sanitary chemistry and other essential instructions for military service. 2d. The position of attending-surgeon in cities having good facilities for medical improvement he filled with young men who were preparing for promotion. These changes did an excellent work, without additional expense to the government; the Museum and Library Building furnished the rooms, and the medical officers on duty in Washington did the teaching in addition to their regular work.

But the number of active young surgeons about Washington and other cities attracted observation, and led the Chairman of the Committee on Military Affairs to conclude there was a surplus of Assistant Surgeons, and in his report to the House he reduced the number from 125 to 90, inhibiting fresh appointments until the number shall be reduced. This recommendation has passed the House, and should it be approved by the Senate will greatly embarrass the Medical Service of the Army and in the end be a detriment to the country, because many military posts will have to depend on civil physicians for medical attendance, and in case of war these would not take the field, and the Army would be without trained medical officers, which would be as serious an evil as unskilled officers in any other department. When these facts were pointed out to the chairman of the committee by other members with better knowledge of practical military affairs, the chairman replied that no one outside of the Army Surgeons had complained, not a single medical society had claimed that an injury would result. Let the American Medical Association at once call the attention of Congress to the mistake threatened.

For twelve years the appropriation for the support of the Library of the Surgeon General's Office was $10,000, but the last Congress reduced it to $7,000, and the present Congress proposes to continue the reduction. This is a National Medical Library, open to and used by physicians from all parts of the country, and the possibility of finding at one place in this country the greater part of the literature on any medical subject has exercised a powerful influence on American medical literature and education. The library aims to obtain every medical book, periodical and report published in any country or language as soon as possible after its issue, and have it at once catalogued and indexed and made available for use. This requires about $7,500 annually. There are still between twenty and thirty thousand volumes of medical books, published years ago, required to complete its equipment to meet all calls made upon it. These volumes are out of print, and only to be obtained from second-hand booksellers and auction sales as opportunity offers, and will involve say $2,500 spent annually for perhaps ten years.

The desirability of supervision of public health by the general government has been recognized by this Association for many years and manifested in various ways. Four years ago a committee, with Dr. C. G. Comegys, chairman, was appointed to prepare a bill, and petition Congress on behalf of the Association to establish a Department of Public Health. This Committee has been continued, somewhat modified, and has reported annually to the Association. Last year the Association appointed another committee, with U. O. B. Wingate as chairman, to consult with a like committee of the American Public Health Association, which has for several years been engaged in an effort to induce Congress to enact a law placing the supervision of the public health in charge of the general government. Other organizations have likewise entered Con-

gress with similar petitions. However, it seems the sentiment of the executive and legislative departments of the government is such as to rob us of all hope of the establishment of a Department of Public Health within the remainder of the nineteenth century. A bureau of public health, with a commissioner as its chief within one of the existing departments of the government was apparently within reach of a united, harmonious, aggressive effort of the profession for a year or two previous to the enlargement of the power of the Marine Hospital service by the last preceding Congress, but the excellent work of that service has lessened the anxiety of the government and the public. The outlook at this time is not encouraging, but if the problems in silver, and tariff and national revenue should be speedily and satisfactorily solved, there might appear a ray of hope for a bureau within the life of the present Congress, provided the medical and sanitary professions would make common and joint effort in demanding it. At present there is no measure formulated in this behalf so worthy of support as the New York Academy bill, now in the hands of Congress. There is no question but strong opposition to this bill has been made by strong men, but the fitness of sanitary human nature for great things is such, that if the opposition to the bill present one better than it, its friends will accept, and if this bill sustains its present status under severest scrutiny, its opponents will join in urging its enactment into a law, and thereby vindicate characters at once wise and patriotic.

Vaccination and other forms of sanitation have prevented an epidemic of small-pox in this country for a generation, and the people have lost the fear of its contagion through ignorance of its nature while progressing, and its sequelæ if its victim survives. The disorders that sometimes follow the insertion of pure vaccine in a cachectic system, and the greater evils arising from the use of spurious or imperfect vaccine and careless vaccination, which are all open to the observation of the public and subject to amplification by cranks and the maliciously ignorant, cause a positive distaste for vaccination among a considerable portion of our population, and a carelessness about securing it on the part of a much larger number. These facts should inspire physicians and other sanitarians who are the custodians of the knowledge of the value of vaccination to redoubled activity in devising and executing popular methods of instruction as to the entire reliability of vaccination to protect from small-pox, as much so as small-pox itself, and that with pure vaccine inserted under proper conditions into the tissues of a person fit to receive it there is positively no shadow of evil, but a promise of good not surpassed by any other single measure of preventive medicine. Evidence accumulates that the undetermined conditions that conduce to the propogation of small-pox are now, and for at least two years have been, prevalent in this country, resulting in outbursts of disease more or less serious in various parts of the country, and too often leaving foci from which fresh infection is distributed. Let us abide in the hope that the Jenner centennial celebration, provided by this Association and to be a part of its exercises at the annual meeting in 1896, may bring out the boundless blessing of the discovery of the immortal Jenner in such wise that all men shall see and acknowledge its protecting power.

Two leading purposes the fathers of this Association had in view at its organization, demanding its serious consideration, were the elevation of the standard of medical education, and that the authority to decide upon the sufficiency of the qualifications of a candidate for a diploma should not rest with his teachers. Much has been done in advancing the extent and character of the collegiate instruction of medical students; the examination of candidates for diplomas is still conducted by the teachers who instructed them, as was done then, and is no more satisfactory to the thoughtful minority of the profession than it was then.

The progress of medicine in the immediate future must be along biologic lines, and it seems desirable that every medical college should have a chair devoted specially to instruction in biology. No one people, or class of people, can claim exclusively to have opened the way into the more primitive arena of nature. The physicists of all nations, botanists, zoölogists, anatomists, physiologists and their congeners have all participated in the progress. Schwan, Virchow, Ferrier, Jackson, Pasteur, Koch and Steinberg may be

mentioned, without prejudice to the labor, name or fame of their many coadjutors, as examples of what benefactors to our race scientists may become whose genius lifts them to a plane of investigation not covered by the curricula practiced in the medical schools of their day, and their distinction is due to their advanced study of biology.

The question of changing the constitution may be readily settled at this meeting by taking a vote to determine whether the voters present desire any change in the existing constitution. If the decision is against any change, the affair is concluded for the once. If the decision expresses dissatisfaction with the constitution as it is, the next question should be: Is the report of the committee of revision precisely what the voters want as a substitute? An affirmative vote here settles the matter, and a negative vote will call for amendments that will adjust either the existing constitution or the committee's substitute, until it conforms to the wishes of the delegates. This may be done without excitement and with a minimum waste of time.

With the Code of Ethics, also, even more than with remodeling the constitution, there is much warmth of feeling; and, as in that case, a little calm forethought will convince that a primary vote involving the question whether or not the voters want any alteration of the Code, may end further consideration of the subject without excitement, confusion or over warmth of feeling, by a decision to let the Code stand as it is, and a contrary decision will call for further procedure, as recited for the completion of an amended constitution.

## NEW METHOD FOR REDUCTION OF FRACTURES OF THE LOWER END OF THE RADIUS.*

THOMAS S. K. MORTON, M. D.,† PHILADELPHIA.

The particular method of reducing fractures of the lower end of the radius, to be described, has proved so satisfactory during the past few years in my services at the Pennsylvania and the Polyclinic Hospitals and elsewhere, and in the hands of others to whom I have from time to time demonstrated it, that I now feel justified in giving to it wider publicity. The method is as follows:

The surgeon stands in front of the patient and interlaces his fingers beneath the supinated wrist and palm of the injured member, so that his two index-fingers lie parallel crosswise beneath the lower end of the upper fragment of the radius. The palms of the surgeon's hands are then closed in upon the thenar and hypothenar portions of the patient's hand respectively, while the surgeon's thumbs rest parallel lengthwise upon the upwardly displaced lower fragment of the radius. The parts are thus firmly grasped by the surgeon while the following movements are made: The patient's wrist is excessively extended by carrying his hand upward. When the hyper-extension has thus been secured the surgeon makes powerful traction upon the wrist in the line of hyper-extension. While this traction is maintained the hand is suddenly carried into full flexion, and at the same time powerful downward pressure upon the upwardly displaced lower fragment of the radius is made by the surgeon's thumbs opposed by the interlaced index-fingers beneath the lower end of the upper fragment.

The excessive extension of the first portion of the movement has always, so far in my experience, loosened or disentangled the displaced lower fragment, while the subsequent traction, flexion, and direct thumb-pressure have not yet failed to accurately force the lower fragment into its proper position. Separated epiphysis of the lower end of the radius is likewise easily reducible by this manipulation. For comminuted or complicated or very

*Read before the Philadelphia County Medical Society, May 9, 1894.

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oblique fractures extension and moulding alone are called for in most instances.

Anæsthesia is unnecessary for making a single effort at reduction by the proposed method. The patient does not anticipate what is coming, the two movements are made with lightning-like rapidity in a small fraction of a second, and, in nearly every case, perfect reduction has been accomplished before the patient realizes that he has been hurt. Should the manipulation fail to secure perfect reduction at the first attempt, I would not repeat the manœuvre until anæsthesia had been induced, for the pain of repeating it would be intolerable. Failing in one effort, then, I would etherize and try again, first, this, and afterward, if necessary, any other method that seemed advisable to secure perfect reduction. But thus far in cases that have been seen within a week of the accident I have never had to anæsthetize since evolving the method mentioned; all have been reduced at the first attempt.

In cases older than one week, with displacement persisting, I anæsthetize before making any effort at reduction. The new method may then first be resorted to, and will often be found the best means of performing both refracture and reduction.

For making a diagnosis I have also found a modification of this method most useful. If the surgeon will take the hand and wrist in which fracture is suspected into his hands, as above described, and, while the thumbs press firmly upon the lower end of the radius or first row of the carpus, make a series of gentle, quick, short flexions and extensions of the joint—rocking it through an arc of perhaps 25 or 30 degrees above and below the forearm as a horizontal plane—he will be astonished at the ease with which crepitus of the bones of the joint and of any small or large bony or cartilaginous fragment will be elicited. And, best of all, the diagnosis of these obscure fractures about the wrist can thus, after some practice, be brought out without giving unbearable pain to the patient. Indeed, I have often this way, by the most gentle and practically painless manipulation, been able to clear up the nature of intricate injuries about the wrist.

By practicing the method upon a normal wrist a sufficient degree of expertness can readily be acquired; by it joint crepitation can be brought out in any wrist. It is well, however, not to practice too much or too often upon the same extremity, as excessive stirring up of the joint contents might originate a synovitis.

In conclusion, the writer desires to say that he will be gratified to have reports of the experience of others who may be tempted to employ the method here put forth.

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### Chronic Bronchitis.

Codliver-oil. During twenty days of the month let the patient take a tablespoonful of the following solution:—

℞
Arseniate of sodium..... gr. iss.
Iodide of sodium..... ʒiiss.
Water..... ʒix.
M.

Every day give four of the following capsules:—

℞
Terpine,
Eucalyptol.....āā gr. iij.
M.

When there is dilatation of the tubes with fetid sputum, inhalation should be made every second hour with

℞
Eucalyptol ..... ʒj.
Alcohol (90 degrees)..... ʒiij.
Water..... ʒvj.

Every day the following potion should be taken:—

℞
Hyposulphite of sodium..... ʒj.
Gummy julep..... ʒiiss.
M.

Every day four of the following pills should be administered:—

℞
Beech-wood creasote,
Terpine,
Iodoform..... gr. ¾.
M.

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### Capillary Bronchitis.

*In the Child.*—In the beginning give an ipecac emetic. Make counter-irritation to chest. Every two hours give a teaspoonful of

℞
Acetate of ammonium..... ʒss.
Malaga wine..... ʒx.
Peppermint water..... ʒv.
Syrup of orange-peel..... ʒij.
M.

*In the Aged.*—Dry cup the chest every two or three days. Let the patient take every two hours a tablespoonful of

℞
Extract of cinchona,
Extract of kola.....āā ʒj.
Old brandy..... ʒx.
Simple julep..... ʒiiss.
M.

In alternation with the preceding mixture administer, every second hour, a teaspoonful of the following cough-mixture:—

℞
Syrup thebaic..... ʒiss.
Syrup of belladonna..... ʒvj.
Cherry-laurel water..... ʒi¼.
Hydrolate of linden..... ʒx.
M.

# ASCITIC DISTENTION OF THE ABDOMEN MISTAKEN FOR PREGNANCY.*

T. RIDGWAY BARKER, M. D.

The following case is reported in order to prove the importance, if not absolute necessity, of making a careful and thorough examination of all women pregnant, or supposed to be, before committing ourselves to a positive diagnosis.

In June, 1891, I first saw the patient, Mrs. M. N.; she was then eighteen years of age, white, mother of two children. There was no history of any miscarriages. Her general health was good and condition favorable for the development of the product of conception which she believed was present, menstruation having ceased in October of the preceding year. Inquiry elicited the fact that her menstrual flow up to that time had been perfectly regular and unaccompanied by pain. Morning sickness proved very annoying for the first three months, but later passed away.

From inspection, abdominal palpation, and digital vaginal examination, the patient was judged to be some six months pregnant, and the date of confinement set for the early part of August. On July 27th, I confined Mrs. N., delivering her of a fine male infant which presented by the vertex.

Labor was accomplished without incident or difficulty, and the lying-in period presented no symptoms suggestive of any organic lesion of the kidney. In fact, it is fair to assume that at that time there did not exist any disease of that excretory organ.

The puerperant's pulse was 72 immediately after delivery, but the temperature was not taken.

I visited Mrs. N. for ten days, when attendance was discontinued, the patient being able to be up and move about her room. Mrs. N. was not seen again by me for over two years, when she called at the dispensary and stated that in the first week in January, 1893, she had suffered from a miscarriage.

The product of conception she passed she presumed was about three months' gestation. The cause of its expulsion I was unable to determine, but ascribed it to a catarrhal condition of the endometrium.

*Read before the Philadelphia County Medical Society, May 9, 1894.

While carrying the embryo she had a slight flow of blood each month which she imagined was her menstrual flow, though she remarked at the time it was of shorter duration and more scanty than usual.

The patient failed to return on the day specified and was not seen again until March 6th, of this year. She stated on presenting herself at the clinic that some months after her last visit to the institution she imagined herself to be in the family-way again and called to see a physician. The doctor, she reported, told her that he believed her view to be correct as to her condition, and that he considered her about four months pregnant, and that her confinement might be expected in December. No vaginal examination was made by him, however, nor did he palpate the abdomen, but based his diagnosis simply upon the results of inspection of the uncovered ventral region.

The breasts were exposed on this occasion and were found to be large, full and globular. The veins were prominent and the areolæ well defined. Milk on pressure, she stated, exuded from the nipples as in former pregnancies. At this time her feet were considerably swollen and the œdema tended to extend up the limbs.

Morning sickness was entirely absent. Leucorrhœa was present, but no remedies were directed toward its treatment. At each monthly period, the patient stated, she had a scanty flow of blood, but thought nothing of it as she had much the same discharge in a former pregnancy. She did not again call on her physician, as she felt no anxiety, having passed through three confinements without difficulty.

When I saw Mrs. N. it was March 6th, nearly three months, I learned, after the date of her expected confinement. She was then suffering from nervous prostration incident in a large measure to the worry occasioned by her delayed labor, she was afraid something was the matter.

Her abdomen, she stated, felt different from what it had ever done before. Inspection of the breasts showed them to present what one might almost say was a condition typical of pregnancy. Even the colostrum exuded on pressure from the orifices of the lactiferous ducts. On

inquiry as to whether she felt fœtal movements, she replied that she did at times, but very slightly. No bearing-down sensations, however, or pain had been experienced.

A glance at her abdomen showed markedly that it was not as prominent as one would have reason to expect it would be in a multipara at full term.

On request, Mrs. N. consented to lie down on the sofa in the dorso-recumbent position, and as she proceeded to do so I was impressed with the fact that the abdomen at once became flattened and broader. This made me suspicious as to the presence of a fœtus, and I at once proceeded to palpate over the region of the supposed pregnant uterus. The abdominal walls were flabby, and the intestines were in contact with them in front but not on the sides. Carrying the examining hand downward toward the pubis I found the uterus wholly within the true pelvic cavity. It seemed about normal in size, and there was elicited no sense of tenderness.

Evidently there was no full-term fœtus in that woman's abdomen. Having secured the patient's consent to a digital vaginal examination, I proceeded to make the same, subject to the rules of asepsis. Inspection of the external genitalia presented nothing characteristic. Passing my index finger up the vaginal canal to the cervix, I found it to be elongated, hard and fissured. The os was small, and from it could be felt escaping a mucous discharge. A sound was passed into the uterus and its cavity made out to measure some three to three and one-half inches.

Search for shreds of membrane or other products of a late conception failed to be productive of any result. The distention of the abdomen was undoubtedly ascitic, and not due to a natural growth of a pregnant uterus.

Further inquiry disclosed the fact that not only had there been for several months œdema of the lower extremities, but also swelling of the face as well. This was especially noticeable about the eyelids.

The urine was passed in large quantities and very frequently. It was of a pale yellow or lemon color; sp. gr. 1010; of acid reaction. No albumen present. Sediment composed of mucus. There had been for many months a gradual but none the less persistent loss of flesh.

The eyesight was very poor, so much so that the woman could scarcely read the newspapers. A kind of mist, as Mrs. N. expressed it, floated before her eyes. Headache was not a troublesome symptom nor was any amount of pain referable to the loins made out. Sleep was troubled and the patient not infrequently awoke in a fright.

Inquiry as to the health of her parents brought forth the statement that her father died, under forty years of age, suddenly in the street, and that he had for some years suffered from dropsy. Her mother was still living and enjoyed the best of health. Mrs. N. has no brothers or sisters. It is not my purpose in this paper to enter into a discussion as to the nature of the kidney lesion, but to lay special stress upon the error in diagnosis which resulted simply from a failure to appreciate and apply the golden rules of obstetrics governing the diagnosis of pregnancy. Had the first practitioner who saw this woman not limited his examination to the breasts, but extended it to the abdomen and supplemented the same by a digital vaginal one, he would not have fallen into the error of diagnosticating a case of kidney disease with ascites one of pregnancy.

The case is a typical example of a "snap" diagnosis and only too clearly proves that the thorough way, which calls for inspection, palpation, ausculation, and digital vaginal examination, though more disagreeable, less brilliant, and tedious, is the only safe and satisfactory one in the long run.

Moreover, we see how little dependence is to be placed upon the patient's statements as to her subjective symptoms. Mrs. N. unhesitatingly told me that she did feel fœtal movements, though they were slight, on the occasion of my first visit, three months after the date fixed for her confinement.

Examination, however, proved her sensations to be purely imaginary. She believed herself pregnant, and therefore, knowing that she should have "quickened," she believed that she did recoguize fœtal movements.

While the mistake in diagnosis in this case did not result disastrously, yet it might under some circumstances have been made the basis of a suit for damages.

One may occasionally make some brilliant "snap diagnoses," but he may rest assured disaster will surely follow if this course is pursued for any length of time.

# TRANSLATIONS.

## THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

### ICHTHYOL IN GONORRHŒA IN WOMEN.

Dr. Jullien (*La Sperimentale*, No. 9, 1894) in the treatment of gonorrhœa in women speaks highly of the local application of a 10 per cent. solution in glycerine, upon a tuft of absorbent cotton twisted around a metallic staff, to the urethra. It is repeated every day and with this procedure he has obtained the best of results, in ordinary cases. A tampon with this same solution may be placed into the vagina to prevent diffusion of the gonococcus.

### THE IODIDE OF RUBIDIUM AND THE IODIDES.

Dr. C. Vogt (*La Bulletin Medical*, No. 39, 1894) at a recent meeting of the Therapeutic Society of Paris, reported a case of syphilitic headache, which uninfluenced by the iodide of potash, yielded rapidly to the iodide of rubidium. He has a favorable opinion of this iodide though it is three times as expensive as the potash salt. Its taste is not pronounced and it is well tolerated. In cases where an iodide is indicated and the potash salt is not well borne, the iodide of rubidium may be tried, especially where the treatment must be prolonged. In the discussion which followed, Prof. C. Paul thought that rather than point out the inconveniences of a new remedy one should try to fix its sphere of curative action and its indications than to make it replace another remedy. The iodide of sodium, which was heralded some years ago as a substitute for the iodide of potash has been demonstrated to be decidedly inferior, both in syphilis and arterio-sclerosis. The iodide of potash is certainly a very disagreeable drug, but it cures, and that is the necessary feature. In some cases it is heroic, but its curative action surpasses its few inconveniences. For example, in aortic affections and especially in atheroma, it will lengthen a patient's life by years, where the sodium salt will be insufficient. In these cases he continues it until the kidneys refuse to tolerate it, when he replaces it with the iodide of strontium. Besides, there are several kinds of syphilitic headache; that of the secondary eruption is easily cured by a few grains of the iodide of potash. He has found the classic measures of combating the inconveniences of the iodide—belladonna, opium, etc., of no service. A diuretic vehicle, as an infusion of corn silk acts best, he has found. Dr. G. Bardet thinks that the association of potash with iodine is essential in syphilis. Dr. Courtade, in twenty patients, has found the iodide of lime better tolerated than the potash compound, but it is less efficacious. Some patients are very intolerant though the majority only show a little or some lachrymation. Dr. R. Blondel stated that if taken in a good deal of water with an equal quantity of the bicarbonate of soda, it is well borne by the most intolerant. Prof. C. Paul also prescribes it in a syrup of coffee, three gms. of the iodide to five hundred gms. of syrup. Even in aortic affections this preparation is well tolerated.

### ICHTHYOL IN PROSTATITIS.

Dr. Scharff (*Journal de Médecine de Paris*, No. 19, 1894) in those cases of posterior urethritis where the prostate is involved, swells, becomes painful, and may increase in size so as to obstruct the large intestine, has found from an experience extending over forty cases, that a ten per cent. solution of ichthyol, in water, of which the patient injects three or four times a day a syringeful into the anus, will give good results. After two or three days of this treatment the patients, who, before could scarcely drag themselves to the consulting room, then walked with ease and passed their stools without difficulty. Rectal examination would reveal the prostate, which before was swollen and painful, to have been reduced to its normal dimensions and painless to contact. He ascribes these favorable results to the action of ichthyol as a sedative contractor of blood vessels, and an absorbent of exudates. Its favorable influence in gynecological diseases is well known.

*In charge of the Translator, F. H. Pritchard, A. M. M.D.

### COLD COMPRESSES IN DISEASES OF THE CHEST.

Dr. Legendre (*Revista de Ciencias Medicas de Barcelona*, No. 8, 1894) in pulmonary affections when there is active hyperemia, prefers wrapping the chest in cold compresses to the ordinary revulsive measures; especially in children, where this procedure may be continued as long as desirable and repeated as often as necessary. Rendu has employed them since 1884 in severe broncho-pneumonia with favorable results. Richardière has used them in sixty cases of broncho-pneumonia in the Hôpital Trousseau, and with satisfactory results. Legendre regards it as the most simple, rapid, and at the same time the most efficacious measure. He has kept children wrapped in these cold compresses for eight days. They act upon the kidneys, keep them well open, and favor diuresis and diaphoresis.

### TREATMENT OF EPILEPSY.

In the *Journal de Médecine de Paris*, No. 19, 1894, the following treatment of epilepsy is recommended:

Preventative treatment: Avoid mental overwork or fatigue, sudden changes of temperature, a too warm or too cold temperature are both unfavorable. Alcoholic beverages, coffee, tea, and too hearty meals are contraindicated. Regulate the bowels, for constipation may bring on an attack.

Treatment during the attack: Place the epileptic upon a bed with his head upon a low pillow, his neck freed from compression or constriction, and protected from injury during violent contractions. If the attacks repeat themselves frequently during the day, one may administer a rectal injection of chloral either alone or associated with the bromide:

℞

| | | |
|---|---|---|
| Chloral..... | | |
| Bromide Potash..... | aa 2 | o (grs. xxx). |
| Yolk Egg..... | No. 1 | |
| Water..... | 200 | o (ʒvjss). |

Administer during an interval.

In traumatic epilepsy surgical measures are the only radical treatment. Traumatic epilepsy may be confounded with cerebral syphilis, and hence the mixed treatment may be tried: the iodide of potash and mercurial inunctions. Intra-muscular injections of the iodide will also render signal service.

Lemoine administers as a reconstituent and nervous sedative the bromides and the phosphates. During the first few months he employs mercurial frictions and the iodide of potash; the next two months the following:

℞

| | | |
|---|---|---|
| Bromide Potash..... | 25 | o (ʒvj). |
| Phosphate Soda..... | 20 | o (ʒv). |
| Syrup Bitter Orange Peel..... | 25 | o (ʒvj). |
| Wine..... | 250 | o (ʒviij). |

A wineglassful after each meal.

In menstrual epilepsy one may administer, every three days, the following powder:

℞

| | |
|---|---|
| Antipyrine..... | 70 (grs. xj). |
| Bicarb. Soda..... | 25 (grs. iv). |

If at the same time there is a marked weakness of the pulse, one may prescribe:

℞

| | |
|---|---|
| Powdered Digitalis Leaves..... | 05 (gr. j). |
| Bicarb. Soda..... | 25 (grs. iv). |

Sufficient for one powder.

*Administration of the Bromides.*—Lemoine claims that the association of hyoscyamine with the bromides forms one of the most efficacious remedies in convulsive states. His formula is as follows:

℞

| | | |
|---|---|---|
| Bromide Potash..... | 30 | o (ʒvijss). |
| Bromide Sodium..... | | |
| Bromide Ammonium..... | aa 15 | o (ʒiv). |
| Crystall. Hysocyamine..... | o | 015 (gr. i-5). |
| Water..... | 1 | litre (o. ij). |

If one should wish a larger dosage, the following then is serviceable:

℞

| | | |
|---|---|---|
| Bromide Potash..... | 15 | o (ʒiv). |
| Bromide Sodium..... | | |
| Bromide Ammonium..... | aa 8 | o (ʒij). |
| Crystall. Hyoscyamine..... | o | 015 (gr. i-5). |
| Water..... | 200 | o (ʒvjss). |

A tablespoonful every evening.

If symptoms of bromism set in, the bromide of gold, which is better tolerated, may be substituted, in the following formula:

℞

| | | |
|---|---|---|
| Bromide Gold..... | o | 20 (grs. iij). |
| Water..... | 550 | o (ʒxvij). |

Every tablespoonful of this solution contains two mgms. ($\frac{1}{30}$ gr.) of the bromide of gold; two teaspoonfuls a day. Lemoine advises taking the bromides either in milk or beer to mask the taste. The borate of soda has been used in epilepsy especially in the diathesic variety.

[Ch. Féré has recently published a paper on the untoward effects of borax when employed as an antiepileptic remedy.—*Trans.*]

### For Neuralgia.

℞

| | |
|---|---|
| Ferri tartarati..... | gr. ij. |
| Quininæ sulphatis..... | gr. ij. |
| Acidi tartarici, | |
| Extract nucis vomicæ..... | ãã gr. ss. |

Misce et fiat pilula. Sig. Take one three times a day.

—*Gross Med. Coll. Bulletin.*

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SATURDAY, JUNE 16, 1894.

## EDITORIAL.

### PUBLIC HEALTH MEASURES—ARE THEY PERFECTED?

Says the *Independent*:—So much is printed in the daily and weekly journals of the land on the Prevention of Disease, and so zealously is the cause advocated by the most advanced physicians, that people are beginning to ask what there will be left for the doctors to do after they have succeeded in teaching us how to avoid all the kinds of decimating bacteria, and after they have taught us how to live truly hygienic lives in perfectly sanitary homes. Certainly these various measures supply us with the best possible armor against the assaults of disease; but there is no fear that as the lay mind becomes more perfectly imbued with intelligence, the physician's occupation will wither and fade. The more a man knows of the structure of the body, the more clearly will he realize that he takes a great risk when he invites an ignoramus to pronounce his crude judgments on, and thrust in his harsh remedies among, the delicate chords of this harp of a thousand strings; so that now on every hand there is a growing demand for a higher education and a more thorough training for our medical men.

This is all very well. The medical profession does not yet see the need of looking around for other employment. Indeed the question has not entered into calculation, for while there is abundant evidence of the great advances in the well-being of mankind, made directly by the efforts of scientific medical men, none are better aware of the fact that sanitary medicine has made but a beginning than are the physicians themselves. The greatest improvement in public health is shown in those nations where the matter of public sanitation and hygiene is committed to the care of the central government. The people of the United States are strangely lagging behind the governments of Europe in recognizing the necessity for systematic supervision of the public hygiene and for the enforcement of health measures by the authority of national law. It is true, that in the national quarantine duties of the Marine Hospital Service, established to meet a threatened

emergency, the United States has a corps of effective, energetic scientists not to be surpassed anywhere; but, the the duty of the Marine Hospital Service is to afford protection from danger from without. Apart from this the care of the public health depends upon the governments of the various states. In consequence we have some painful contrasts. Some of the states have established Boards of Health, with ample provisions for effective organization for the work, and endued them with sufficient powers to enforce such measures as they may find necessary for public welfare. Other states have established similar Boards of Health, but have neglected to render them effective. Still other states have not as yet evolved sufficiently to appreciate the advantages of public hygiene, while at least one state has made the woeful blunder of abolishing its State Board instead of strengthening its hands.

Contrast the recent situation in two of our Southern States. A year ago small-pox made its appearance in that portion of Virginia projecting between Tennessee and Kentucky. Virginia has no health boards in that region, no means of restraint or quarantine; but the intelligent and wide-awake health officers of Tennessee were instantly on the alert. In Chattanooga, November 7th, 1893, a case was reported. At once the State Board of Health sent out a warning "leaflet" to every county and town health officer in the State, giving minute directions for preventing and controlling the disease, and, as the secretary truly says, "this course disarms terror, prepares the public to await results with coolness, and enables health officials to have inspectors, nurses, hospitals and all other appliances now required by sanitary progress, in readiness." Whenever a fresh outbreak occurred the warnings were repeated, and the press throughout the State united in calling for vigilance. The secretary, who enthusiastically worked through a great many years of public apathy, now cheerfully adds:

"At no period since the establishment of the State Board of Health has so systematic and thorough co-operation prevailed with local workers. These are rapidly learning the great advantage to them of information, and authority emanating directly from the central health department."

There were but a few scattered cases in the State, in spite of its nearly half a million of colored people, who have been regarded as peculiarly liable to the infection, as they are crowded together in the cities and towns.

Georgia did not believe in such foolish notions and abolished her State Board. How colossal and fatal was this blunder was demonstrated last fall in the paralyzing scourge of Yellow fever in her principal seaport town. It was a matter for congratulation not only for that city and state but to the entire country that there was organized federal help for her through the United States Marine Hospital Service.

Small-pox this past winter has been more or less prevalent throughout portions of the United States, but it has failed to reach the proportions of an epidemic, because of the watchful care and effective provisions of the various health authorities brought in contact with it. In 1872, an epidemic of small-pox swept around the world. It found nations which had been free from its ravages so long that they had ceased to fear it, and had become careless of providing against it. Vaccination had gone out of fashion. The epidemic of small-pox promptly re-established it in public favor, and many countries enacted laws with severe penalties for compulsory vaccination. The same conditions hold true to-day, though greatly modified by increased intelligence and knowledge. But we yet hear the old

objections and superstitions against the protection of the public by vaccination, compulsory if necessary. The almost total absence of small-pox from the German Empire, and its entire suppression in the army where vaccination and re-vaccination at stated periods is compulsory, show that intelligence and organization have achieved, and Holland handsomely swells the catalog. Between the years of 1870 and 1873 there were 20,575 deaths; but a stringent law for compulsory vaccination being enforced, there was but one death throughout the kingdom in 1890.

It is well to bear in mind that a single vaccination, however effective temporarily, probably does not confer life long immunity, and the more recent authorities are inclined to recommend multiple inoculations.

## ABSTRACTS.

### INTESTINAL OBSTRUCTION DUE TO OCCLUSION OF THE ILEUM BY PRESSURE BAND.

Robert Jones reports (*Br. Med. Jour.*): On Tuesday, December 19th, 1893, I was asked by Dr. Hugh Shaw to examine a case of intestinal obstruction. The patient was H. A. S., a milliner's apprentice, aged 14. On December 7th, whilst at her work, she was suddenly seized with violent pains shooting across the abdomen in the line of the umbilicus. She vomited several times on her way home, and, on her arrival, went to bed. A little later her bowels were freely moved. This attack was not regarded seriously by her family, and as the acute symptoms seemed to abate domestic antidotes were relied on. For two or three days she remained in considerable pain, with occasional sickness, when her mother administered a copious soap and water enema. This gave temporary relief by emptying the large bowel of gas, but the pain and vomiting returned with severity, and on December 13th, Dr. Shaw was sent for. He found the patient in great pain, with moderate distension, good pulse, moist tongue, and normal temperature, and thinking it best to act conservatively, he gave appropriate directions with a view to lessening intra-abdominal pressure and to relieving pain. All the symptoms, however, increased, the pain becoming intense, and the vomiting more and more frequent, while the temperature remained at about 102°F. On December 15th, the vomiting became fæculent, and from that time until December 19th, when I first saw the patient, nothing was retained. She then presented symptoms of impending collapse—a small quick pulse, dry tongue, a haggard look, listless demeanor, and rapid shallow respirations. The abdomen was distended and tympanitic, especially round the middle line. Fæculent material was being vomited every few minutes, thirst was intense, and there was pain on pressure over the right side of the abdomen. The patient, despite all this, was mentually alert, and took an intelligent interest in her affairs.

I was told she had been a well-developed girl, and well nourished, and had never needed a doctor in her life. For the last four years, however, she had been subject to what were called bilious attacks, the prominent symptom of which was vomiting, which lasted for one or two days, and was often accompanied by pain and sometimes by diarrhœa. For twelve months she had had considerable pain in the epigastrium, which came on directly after food and often resulted in sickness. About two years back she suffered great pain in the right side on exertion, more particulary if she attempted to walk quickly or to run.

We decided, in view of the previous history and the patient's condition, that laparaotomy should be performed without delay. That evening a median incision 3 or 4 inches long was made below the umbilicus, and the cavity of the abdomen exposed. Distended gut, pinkish in color and dotted with flaky lymph, pre-

sented. On introducing my finger, the coils of intestine were sufficiently adherent to each other to require care in separating them. I was able quite easily to recognize the cæcum, and found it collapsed. There were also in the pelvis a few coils of empty small intestine. By very gently following this without exposing bowel, I felt a distended loop of intestine, which was carefully brought towards the wound. Immediately below I found a band about half an inch broad, which obviously compressed the intestine. I did not feel justified in accurately defining its limits, but it stretched transversely across the gut from the direction of the right kidney. The bowel was not kinked, but was sufficiently pressed upon to be quite occluded. Ligatures were applied and the strand severed. The wound was adjusted, and the patient placed in bed. Here a somewhat dramatic incident occured. It was found that owing to a blunder a sponge was short. After a brief and fruitless hunt, in basins, pails, and *debris*, I decided to reopen the abdomen. Luckily this was done, and the sponge recovered from within.

It is needless to report the subsequent events at length. The operation, which only lasted twenty minutes, had but a very slightly depressing action on the patient. The vomiting once and for all completely ceased. The temperature was normal next morning, and only once again, on the third day and for a few hours, rose to 101°. On the second day (December 21st) there was a suspicion of the passage of flatus; on December 22nd, a certainty of it; on December 24th, the tongue became moist, and the bowels were opened at 3 P. M. and 4 P. M. The first motion, about 4 ounces, was similar to the vomit, the second consisted of mucus. Shortly following the evacuation there were sharp abdominal pains, and the tongue became a little dry. From this time on the bowels were frequently opened, and the patient rapidly got well.

There are a few points of interest to which I would wish to allude. 1. The operation was performed on the twelfth day of obstruction and during considerable abdominal distension. I have often expressed an opinion that it is useless and dangerous to hunt for obstruction while peritonitis and distended gut are present, and that the indications are best met by a carefully performed enterostomy; opening of course a distended coil. The empty condition of the cæcum, however, together with the collapsed small intestine, pointed to obstruction high up—a condition ill-suited for enterostomy. Again, although the obstruction was high up, fæcal vomiting did not appear for eight days, and this suggested that probably the obstruction, very incomplete at first, became more complete by distension from above, and that had care been exercised early the symptoms might have continued, as they had begun, to abate.

This opinion is fortified by the fact that the pain she complained of during exercise and hurry was over the neighborhood of the band, and that probably her frequent so-called bilious attacks emanated from the same source. Amongst the causes which deprive an early obstruction of a fair chance, next to cathartics, should be placed enemata, which, as Niemeyer pointed out years ago, induce peristalsis above as well as below the seat of obstruction.

There was another symptom in this case which interested me, and that was the sharp abdominal pain which followed shortly after the anal evacuation. I have frequently observed this before. In one case, which was being treated expectantly, the patient died on the twentieth day, four hours after the relief of obstruction, having endured sharp abdominal twinges. In another case after the relief of a very simple hernia, an evacuation of bowel took place, followed by collapse and death.

---

### Colorless Iodine Ointment.

℞ Iodi..... gr. xx.
Potassii iodidi..... gr. iv.
Sodii sulphitis..... gr. xl.
Aquæ..... q. s.

Rub the chemicals with the water until the solution becomes colorless. Then add:—

Adipis benzoati..... ʒj.

M.

—*Atlanta Clinic.*

---

### Whooping-Cough.

The following formula comes from the Rotunda Hospital of Dublin:—

℞ Zinci sulphatis..... gr. iv.
Tincturæ belladonnæ..... mxlviij.
Aquæ anisi..... ad ʒij.

Misce.

Sig. Twenty drops every third hour for a child one year old, thirty for a child three years old, sixty for a child five years old, and so on.

—*The Southern Clinic.*

# SOCIETY REPORTS.

## THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

*March 9, 1894.*

STENOGRAPHICALLY REPORTED BY C. C. MAPES.

Discussion of Dr. T. L. McDermott's essay continued from THE REPORTER of June 16, 1894, on

APPENDICITIS FROM A MEDICAL STANDPOINT.

(See page 813)

DR. A. M. CARTLEDGE: The more I study the subject of appendicitis the more I find to be hnown in connection with it. When I I thought, five years ago, that I knew a great dral about appendicitis, I find that I knew very little about it, and I want to say once for all that my views on the disease, both as to pathology and treatment, time of operation and diagnosis hnve been the subject of constant change. Even a year ago had I been interrogated as to the nature of the trouble where a patient had recurrant attacks of pain and a lump in the right iliac region, with temperature of 101°, I would have said "catarrhal appedicitis" and advised agaiust operative procedure, believing that the case would probably get well. If evidences of pus were present I would have waited until I thought there were anterior peritoneal adhesions to serve as protection to the general peritoneal cavity, then go ahead and open the abscess and drain it, removing the the appendix. If asked the question what I would do in the perforative type, where rupture had occurred primarily, with the possibillities of pus in the abdomen, I would have answered just as I would at the present time, that operation is imperatively demanded at once. I now believe that all cases of appendicitis can be so diagnosed without question, should be operated upon. As you all know I differ with the majority of surgeons in regard to the pathologic classification of this affection. For instance look at the discussion of the subject to-night, what variable course it leads, Here is a gentleman who says, from what knowledge we have of the clinical manifestations and clinical history of these cases that there is no material difference between appendicitis and the older terms of typhlitis, perityphlitis, etc., and further makes the statement that there is no case of appendicitis that ought to be operated upon; that he would not advise operation in any case. If this does not call for some more definite classification of this disease, I cannot conceive of anything that would do so more than this discussion to-night. To revert to the specimens shown at the last meeting of this Society, I selected three specimens, illustrating three types of the disease. My object in presenting these specimens was to try and throw some light on the pathology and classification of the disease. In the specimen Dr. Anderson has mentioned, which was a case operated upon the day of the meeting, there was a distinct stenosis about one-half inch from the base, the result of cicatrization of former inflammation; there was a history of several attacks of undoubted appendicitis; the appendix was found coiled up behind the cæcum and adherent, enormously distended with liquid fecal matter and pus. The appendix was slit open in order to show the stricture. It was a typical case of so-called catarrhal appendicitis, a condition which I claim cannot be recognized and does not exist. I claim that all lesions in this situation, sufficiently well-marked to be denominated appendicitis, are primarily ulcerative or perforative in type. Those cases heretofore called catarrhal appendicitis I am confident were ulcerative in character, which led to stenosis at some portion of the lumen of the appendix. It was to illustrate this point particularly that I exhibited the specimen.

It seems that the point which has attracted the most attention in regard to the specimen presented, was the pathological condition, and this is the very point that I regarded as being the most apparent. There was plainly stricture, the continued contraction of which will eventually lead to either one of two pathological terminations—complete stenosis with distal distension and rupture, or retention with infection and general septic inflammation of the appendix leading to necrosis and perforation. The case was operated upon before rupture had taken place, and the result shows the wisdom of such a procedure.

As to exploratory incisions being harmless —it is probable that they are not harmless, but by this means of confirming diagnoses we have been enabled to clear up a very wide field of surgery. Twenty-five years ago the greatest problem before the surgical world was the diagnosis of ovarian cysts, but matters are now so thoroughly understood that even the country practitioner is able to make the diagnosis without question. Since this

is true of exploratory incision in ovarian tumors, I see no reason why the same rule should not be applied in appendicitis to the end that we may better understand the pathology. In our present understanding we know that occasionally other conditions present pathological features which can hardly be differentiated. I remember having operated upon what I thought to be a typical case of appendicitis, which proved to be tubal pregnancy. The sac and contents were removed and the lady made an easy recovery.

The question of hernia following appendisectomy has been mentioned. Of course, we must admit that hernia is more common following any operation where the incision is made out of the median line, but I believe with the proper after-treatment this liability to hernia can be reduced to a minimum.

Dr. McDermott suggests that physicians ought to become more careful about advising operations for appendicitis. I heartily endorse this portion of his remarks, but the deduction he makes is entirely from the standpoint of observation. While a man's past experience is very valuable as a guide still it should not be entirely convincing. The probabilities are that men to-day are operating for appendicitis who a year or two ago would have advised against it. I cannot understand how a man can stand up and say that operation for this disease is not advisable and should not be performed in any case, when he has seen the abdomen opened, where the appendix has been found perforated and gangrenous, and the cavity filled with pus.

There is nothing that will regulate the operation for appendicitis, time for operative interference, etc., etc., save a better knowledge of the pathology of the affection. Treeves and some others quoted to-night, do not refuse to operate upon patients suffering with suppurative appendicitis, demonstrating very clearly that they recognize the necessity of surgical measures. The mistake, I think, that nearly all authorities make, is that they continue to classify the affection as "perforative," "ulcerative," and "catarrhal." As I have stated before, I fail to see how catarrhal conditions of the mucous membrane can produce symptoms which can be recognized in connection with the appendix, or by which the condition can be diagnosed. I claim that it is utterly impossible. Then the question might be asked to what can we attribute such symptoms? I say that the specimen I exhibited at the last meeting of this Society fully demonstrates to be an ulcerative, inflammatory condition, resulting in stenosis and distal distension and finally perforation and septic infection extending to the peritoneum and structures surrounding the appendix. From the anatomy of the appendix it will be apparent that a part of the caecal contents may be forced into it, and may again be discharged into the caecum. We know that fecal matter does not normally occupy the appendix, its contents being only a mucous secretion, and I take it when fecal matter is found it is *prima facie* evidence that the appendix or the door to its entrance is diseased. This is interesting in connection with the so-called cures of appendicitis by the administration of opium, etc. A man has an attack of what is diagnosed by the attending physician appendicitis. He is treated by the usual medical methods and recovers. Some time afterward he has another physician, and under similar treatment again recovers. Say he has six or seven such attacks, and is seen by as many different physicians, each of whom record it as a cure without operation. Finally he has a more severe attack, perforation evidently takes place; the patieut is referred to a surgeon, is operated upon, and dies. Of course the death is only recorded once and the case is recorded seven times as cured by medical treatment. Therefore statistics as quoted by our essayist, under these conditions would seem to be of little practical value. I am not inclined to believe that undoubted appendicitis is ever cured except by operative treatment. The appendix may become distended and, if the stricture is not complete, the contents may be discharged back into the cæcum, but it does not necessarily follow that the patient is cured, for the probability of future trouble is very great.

Another point: Microscopical examinations have proven that a great many of these cases are tuberculous in character, and I claim that we have no right to leave tuberculous structures anywhere in the body, because the patient is thus subjected to great danger of general tuberculous infection. The same thing is true of pus, no matter in what organ or structure it may be discovered.

When statistics are quoted to us that 95 per cent. of the cases of appendicitis recover spontaneously, they are certainly the first, second or third attacks, as I have before indicated. In other words it is the point of observation from which you look at them. While Dr. Anderson and the other speakers may have treated cases of undoubted appendicitis which recovered, and some of which may still apparently remain well, it is no sign that they may not yet develop a perforative attack and die. I believe that when the appendix is once diseased, where there is ulceration it will be followed by stenosis and the patient will be liable to subsequent attacks, any one of which may result fatally. Mortuary statistics show that such deaths result from peritonitis, while I believe the facts in the case would show that the patients died of appendicitis. There is no doubt in my mind

that ninety-five out of every hundred cases of peritonitis in the male are the result of appendicitis.

One word in regard to the diagnosis: Rigidity in the right iliac region; localized pain, acute in character; elevation of temperature over 100° F. and vomiting, are indicative of appendicitis ninety-eight times out of a hundred, and demand operative interference. In the other two per cent. the mistake is pardonable for the good done the ninety-eight.

DR. W. L. RODMAN: He who says that operation should *never* be performed for appendicitis is certainly wrong; on the other hand, those who say that the *great majority* of these cases should be operated upon, are as far from the truth. I am satisfied that the tendency in this country is to operate too much for this affection. I cannot understand how any man can say that there will *not be found* cases of gangrenous appendices that ought to be operated upon; cases that cannot be relieved in any other way. I believe the *middle* course is the safer. Further, I believe in the English practice of operating between attacks, as we find our patients in the best condition to withstand a laparotomy.

## PROCEEDINGS OF ASSOCIATION OF AMERICAN ANATOMISTS.

The sixth annual meeting of the Association of American Anatomists was held in conjunction with the Congress of American Physicians and Surgeons, in Whashington, D. C., May 29th to June 1st, 1894.

The Secretary reported that Dr. Chas. B. Ewing, Assistant Surgeon U. S. A., and Dr. F. C. Schaefer, Professor of Anatomy in Chicago Medical College had resigned, and that three members had died, namely: Dr. Wm. Lee, Professor of Physiology, Columbian University, Washington; Dr. Wm. B. Towles, Professor of Anatomy and Materia Medica, University of Virgina, and of Anatomy, University of Vermont; and Dr. Corydon C. Ford, Professor of Anatomy and Physiology, University of Michigan.

The following new members were elected: Dr. John A. Boger, Assistant Demonstrator of Anatomy, University of Pennsylvania; Dr. H. B. Ferris, Assistant Professor of Anatomy, Yale University; Dr. Robert L. Greene, Professor of Anatomy, University Medical College and Western Dental College, Kansas City, Mo.; Dr. Wm. Keiller, Professor of Anatomy, University of Texas; Dr. Joseph Leidy, Assistant of Demonstrator of Anatomy, University of Penna,; Dr. Mary B. Moody, New Haven, Conn.; Mr. Robert O. Moody, Yale Medical School; Dr. Chas. D. Smith, Professor of Physiology, Bowdoin College; Dr. Wm. O. Stillman, Albany, N. Y.; Dr. W. C. Woodward, University of Georgetown, Washington, D. C. Sir Wm. Turner, of London, was elected an honorary member.

The officers elected for the ensuing term were: Dr. Thos. Dwight, of Harvard University, for President; Dr. B. G. Wilder, of Cornell University, first Vice-President; Dr. F. J. Shepherd, of McGill University, Montreal, second Vice-President; Dr. D. S. Lamb, Army Medical Museum, Washington, Secretary and Treasurer; Prof. C. L. Herrick, Denison College, Granville, Ohio, delegate to the Congress of American Physicians and Surgeons; Dr. D. K. Shute, Columbian University of Washington, D. C., alternate; Dr. Theo. M. Gill, Smithsonian Institution, Washington, D.C., was elected to the vacancy in the Executive Committee.

The following papers were read: "On the Identity of Structre of Protoplasm with that of Striped Muscle," by Dr. Carl Heitzmann, of New York City. "Some Problems Relating to Cerebral Fissures," Dr. Wilder, of Cornell University. "A Plea for a Methodcally Written Text-book on Anatomy," by Dr. Edmond Souchon, Tulane University, New Orleans. "Study of the Human Cranium," also "The Shortening of the Face-axis in the Evolution of the Mammalia," by Dr. Harrison Allen, University of Pennsylvania. "Methods of Estimating the height from parts of the Skeleton," by Dr. Dwight, Harvard University. "The Perineum and Perineal Body." Dr. Shute, of Columbian University, Washington, D. C. "The Study of the Muscular Tunic of the large and small Intestine of Man in the Region of Caecum," also, "A Note on the Occurrence of the Scapulo-Clavicular Muscle," by Mr. Moody. "Theoretical Anatomy of the Sympathetic System," Dr. Wm. Carr, Columbian University, Washington. "The Female External Genital Organs: a Criticism on Current Anatomical Description," Dr. Lamb, Army Medical Museum, Washington, D. C.

The following papers were read by titles in the absence of the authors: "In Our Two Years' Study of Anatomy: What partof the Subject should be covered in the First Year's Work, What part in the Second?" by Dr. A. D. Bevan, Rush Medical College. Two papers by Prof. P. A. Fish, Cornell University, namely: "The Form and Relations of the Nerve-Cells and Fibres in Desmognathus Fusca;" and "The Terminology of the Nerve-cell."

An abstract of these papers and the discussions will be published with the proceedings of the Association.

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL

contains an article by A. S. Wheeler, D. V. S., on

**Tuberculosis.**

In this the author states that tuberculosis may result in human beings from the use of either the milk or meat of infected animals, and that there are no "known creatures, inhabiting air, land, or water, which may not be the hosts" of this disease. He gives quite a list of birds and quadrupeds, which various observers have found infected, and states that with tubercle, as with anthrax bacilli, the earthworms may play a prominent part in bringing the dangerous organisms to the surface of a pasture, and he goes on to show that other cattle diseases are caused to spread through herds through the ministrations of parasites (the grub, the cattle tick, etc.)

Dropping speculation, statistics are quoted to show that very few calves are tuberculous at birth, but the percentage increases with their age, up to seven years or more, and still more significant is the fact that cows are more frequently affected than bulls and oxen, by an enormous ratio.

One great reason for this preponderance among cows is the habit of choosing a cow with a narrow chest and wide pelvis for breeding for milk; but another is the crowding of numbers of cows in a poorly-ventilated stable throughout the greater part of the year, to obtain milk for city consumption.

The author passes on to meat inspection, and speaks of the old church laws, and particularly the Jewish laws, which compelled the rejection of meat of unhealthy animals, and mentions the discovery he made in a slaughter-house, of a tuberculous liver, weighing fifty-one pounds, which had come from a dairy cow.

The article of Prof. Law is now partially quoted, showing the extreme probability of a constitutional disturbance from the absorption of toxins due to the presence of tubercle in an animal; but not necessarily depending on tubercle in the human being secondarily affected.

Koch's tuberculin, although perfectly sterilized, gives a decided reaction in any one who is already infected with tubercule, and greatly increases the destruction going on. While it has not yet been proved by Prof. Law that these toxins can originate tuberculosis in any one, it is evident that cooking the milk or meat is not sufficient to prevent a person, already slightly affected, having the reparative processes stopped and the destructive ones stimulated by the ingestion of these toxins.

The author closes with a plea for the systematic use of tuberculin as a scientific and absolutely sure test for tuberculosis in cattle, and for the destruction of those beasts reacting to it.

In the same number Dr. B. A. Pope reports a

**Case of Hysterical Alexia, Cured by Suggestion.**

The patient was a girl 13 years old, beginning to menstruate, and who had formerly been very bright, cheerful, etc. The child seemed dull, rather indifferent to her surroundings, and was very anæmic. She complained of almost constant headache and of inability to read or to sew.

There was inequality of pupils, and mild photophobia, and testing without glasses gave V-$\frac{20}{200}$ for each eye; but with the trial frame $\frac{20}{20}$ in each eye, and in both. On removal of the frame the former condition appeared.

Under atropine the vision was for each eye, H=0·50 D. Glasses were prescribed +0·25 D for each eye, and worn constantly, and as a result she reads well, does fancy work, and has improved in general condition.

The author thinks that this child had, through association with children who wore glasses, became convinced that glasses were necessary to good vision. He does not think this case resembles hysterical amblyopia; but is rather like some recent German cases which have usually occurred in boys and, being under the age of puberty, had no sexual cause.

Dr. Otto Lerch has an article on

**Geology and Medical Science.**

He regards a knowledge of geology a very important aid to a physician, particularly in ordering a change of climate; but, also in recognizing with more certainty symptoms complained of as due, in part at least to the climate, soil, and water of the place in which his patient lives, and to be remedied by removing him.

In regard to choosing another climate for an invalid—the mistake would not be made, by one thoroughly versed in the physical geography of the country, of sending a consumptive to the western prairies. These lands are elevated and dry; but, owing to their sudden blizzards, are subject to a change of temperature of possibly sixty degrees, the author states, in an hour.

Then also, a mineral spring may contain a very desirable water; but, if situated in an unsuitable region it would be folly to send a patient to it.

Dr. Henry Burchard read before the Philadelphia County Medical Society a paper on

**Gout and the Teeth.**

Trifacial neuralgia is more frequently due to irritation of the teeth than to any other cause, the author says, and numerous other disorders are more or less aggravated, and continued, by faulty teeth. Specialists in rhinology and ophthalmology recognize these facts, but general practitioners generally seem to ignore them.

The difference between diseases affecting the tooth pulp. and those limited to the pericementum was explained, and the different lines of treatment called for.

A disease known as pyorrhœa aveolaris, or phagadænic pericementitis, has attracted attention for years, and is the cause of the loss of as many or of more teeth than dental caries. It is a progressive destruction of the peuiosteum of the teeth, and this, and erosion of the teeth, the author thinks due to a gouty diathesis.

Dental erosion is a progressive loss of tooth substance by decalcification, a chemical solution of the lime salts, and not associated with caries. It is largely confined to those surfaces in contact with the labial and buccal mucous membranes.

"Phagedenic pericementitis is a degeneration of the retentive apparatus of the teeth, which arises without mechanical violence, specific virus, or the selective action of drugs, and proceeds to its termination with, or without, the formation of calcic deposits and true pus (although the pus and deposits are usual associates), the process terminating with the loss of the teeth." Men and women are both subject to this disorder, and although cases occur before thirty years of age, they are rare.

Two types of this affection, depending on the part of the membrane attacked, are known. The more common of these begins as a marginal disease, a deepening of color and a softening of gum at the tooth margin. This increases, and by the time it attracts attention a separation is beginning between tooth and gum. Pockets form, and in them are pus and concretions; these increase, and finally result in the casting of the teeth, as foreign bodies, and the processis usually ended. In contradistinction to salivary calculi, the concretions form beneath the gum, instead of on it.

In spite of local therapeusis, this disease recurs or persists, and for this reason a constitutional cause has been assigned to it.

In dental erosion we find, in situations where the lactic acid due to fermentative micro-organisms is in least amount, a progressive loss of enamel, and then of dentine. One or more grooves may be seen on the labial surface, the enamel destroyed in greater amount than the dentine—the reverse of caries.

In most of these cases a history of gout can be obtained, or, if not, the disease appears later.

The author goes on to describe gout in its better known phases, and to give its causation, pathology, etc., and then states that the most satisfactory treatment known at present seems to be by lithium, and particularly by lithium Rochelle salt, in which part of the sodium is replaced by lithium, and quotes Bartholow as saying that manganese is useful, both by relieving the disorder and by assisting in oxidation.

In the discussion which followed, it was stated that uric acid, urates of soda, etc., have usually been found in these concretions, when they have been analyzed.

Dr. S. Solis-Cohen showed a case of

**Acromegaly,**

which he had treated with thyroid powder, so far with benefit.

The patient, a man of about fifty-two years, had applied for treatment for excruciating headache, which prevented his lying down, and which was increased by pressure on the scalp.

Examination demonstrating symptoms of acromegaly, the patient was put on treatment of desiccated thyroid gland, and improved from it.

One of the symptoms was polyuria, and as thyroid powder usually increases the urine, it was thought strange that it lessened it in this case. The author thought this due to a lessening of the production of the toxins causing the symptom. Five grains of a powder prepared from desiccated sheeps' thyroid glands was given every morning.

Other papers in this issue are: "A Description of a Case oi Circumscribed Scleroderma or Morphœa," by Dr. George Kreegen, and a Clinical Lecture on "Hydrosalpinx and Pyosalpinx," by Dr. Angustin H. Goelet.

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### Dyspepsia.

When accompanied by hyperacidity of the stomach, with pain or vertigo, Robin prescribes:—

℞

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|---|---|
| Bitartrate of potassium | ʒiij. |
| Sublimed sulphur | ʒiss. |
| Prepared chalk | ʒss. |
| Dover's powder | gr. xv. |

M. and divide into 10 powders. One powder to be taken before each meal.

If the pains are severe:—

℞

| | |
|---|---|
| Hydrochl. of morphine, Hydrochl. of cocaine | āā gr. ½. |
| Lime-water | ʒij. |

M. Sig. Teaspoonful at a dose.

—*Le Prog. Med.*

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### Diabetes Mellitus.

In order to relieve the dryness of mouth, which is often so troublesome, the nitrate of pilocarpine,—$\frac{1}{6}$ grain,—made up with a sufficient quantity of glycerin and gum to form a small pill, may often be used with advantage. From five to seven pills are taken during the day, being allowed to dissolve slowly in the mouth. It may be applied in solution, if preferred:—

℞

| | |
|---|---|
| Nitrate of pilocarpine | gr. ¼. |
| Alcohol of 40 degrees | mxc. |
| Distilled water | ʒij. |

M.

The tongue is moistened with five or six drops of this mixture, either pure or diluted with ½ drachm of water. The application may be repeated four or five times during the day.

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### Vomiting.

*The American Doctor* says that oil of cloves in ½-to 1-drop doses, given in a suitable menstrum will control excessive vomiting.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Tobacco Smoke: Its Action as a Microbicide.

What has the French Society of Hygiene to say against the abuse of tobacco? We see in the *Italia Terniale*, of February 21st, that after many experiments Prof. Tassinari is going to publish an interesting work, of which the following are the conclusions:

1. The smoke of the Cavour, Virginie and Toscan cigars and black and short cut tobacco possesses a very great bacteriological power, especially against the bacillus of Asiatic cholera.

2. This action as a microbicide seems to be, according to all probability, due to the empyreumatic products of the nicotine.

3. In cholera and typhus epidemics the use of tobacco may be useful rather than injurious.

4. Tobacco smoke deserves careful consideration in regard to the hygiene of the mouth, as a preventative of diseases.

In 1832, when the cholera epidemic spread through the Mediterranean and menaced Paris, we smoked our first cigar, without any enjoyment and with the inconvenience of a novice in smoking, because we were told that cigar smoke prevented cholera. To-day they say it destroys bacteria. That is all the difference.—DR. DE F., *Journal d' Hygiene.*

### The Therapeutics of Oxygen.

Dr. A. W. Catlin, of Brooklyn, states that the therapeutic use of oxygen is of very recent date. The treatment of disease by natural means is proving more and more efficacious as experience increases. Oxygen is a distinct remedial agent—one that should not be left untried until the patient is *in extremis*. It is the surest and most satisfactory stimulant that we possess, and is applicable to many conditions. In profound shock, from whatever cause, it has been found to exercise a reviving effect. It is taken up quickly by the blood, but its chief value is in its effect upon the nerve centers, upon which it exercises a quiet and soothing effect. In hemorrhage from typhoid fever he has seen relief in many cases. It would produce sleep, favor assimilation and shorten the period of convalescence. No agent is so well tolerated or so useful in restoring the equipoise of the physical condition. In cases of child-birth, pneumonia, bronchitis, and other exhausting diseases, the use of oxygen is indicated, and it should not be given late, but early.—*New York Medical Journal.*

### Physical Diagnosis of Biliary Calculi.

C. Gerhart calls attention to the early symptoms of biliary colic. The attack begins often four to five hours after a hearty meal, or when the food passes into the duodenum, causing, by a reflex action, an expulsion of bile from the gall bladder. This will produce a temporary sensible enlargement of the sac (supposing that obstruction of the duct exists, and the gall cyst retains its distensibility). This enlargement subsides as soon as the stone has passed; the localized inflammation having produced some peritonitis, a circumscribed area of crepitant rales can be heard with the aid of the stethoscope. This, together with pain, may exist some little time after the stone has found its way into the intestine. This latter condition is often greatly ameliorated by applications of ice water. An extension of the peritoneal inflammation to the pleura is but rarely observed. As a most frequent complication, we have an appendicitis due to a mechanical or chronic obstruction. If the attack is prolonged, the liver becomes enlarged, and its edges can be easily palpated, and often seen, if the patient is emaciated. Transient enlargement of the liver, one of the important symptoms, is also met with in cholelithiasis, or when the ductus communis is obstructed by ascaris lumbricoides, or other catarrhal inflammatory exudations. The head of the pancreas is also the seat of a new growth or swelling, thus producing mechanical pressure upon the duct; on the other hand, it is absent in cardalgia or purely nervous hepatic colics.

Cholelithiasis can be excluded if there be an absence of crepitation over the seat of the gall cyst—if there is no enlargement of the same, and if after several attacks there have been no calculi found in the fæces.—*Deut. Med. Wochen.*

### Salicylate of Sodium in Cancer.

In a case where the bone had become involved, secondary to cancer of the breast, Aikmann obtained decided relief of pain by the administration of salicylate of sodium in doses of 10 grains three times a day. Large doses of opium had been given in vain.—*Glasgow Medical Journal.*

### The Ice Bag.

There are probably few persons who are acquainted with the great value of the ice bag, especially in the treatment of acute inflammatory conditions. It is useful in the early stages of all acute inflammations, such as pneumonia, pleurisy, peritonitis, pelvic cellulitis, erysipelas, etc. It must be remembered that the ice bag should be used only in the first stages of the disease. At this period it checks the growth of the microbe upon which the inflammation depends; and, by lessening the blood-supply, prevents in a large measure the exudation and other mischievous processes which accompany acute inflammation. The ice bag may well replace, in the early stages of inflammation, the time-honored

poultice, which is at best an unclean remedy, possessing no other virtue than that of moisture and warmth.

It is important to remember that cold has a depressing effect; hence the application of the ice bag should be carefully watched. Except when the application is made to the abdomen or very fleshy parts of the body, one or two thicknesses of flannel should intervene between the bag and the skin, so as to prevent chilling to such a degree as to produce sloughing. It is also well to remove the bag every two or three hours, and apply a fomentation for fifteen or twenty minutes.

In most acute inflammations, the application of the ice bag must be limited to the first twenty-four or thirty-six hours; at the end of which time, and sometimes before, the ice bag should be replaced by cloths wrung out of cold water, and the application of heat should be very frequent, say every two or three hours. After two or three days, continuous warm applications should be used in place of the ice bag.—*Modern Medicine.*

### Pleurisy.

℞ Guaiacol pure..... 5j.
Tinct. iodine..... 3vij.

Paint the whole of this liquid each evening on the affected side. The temperature quickly falls, an abundant perspiration takes place, and the effusion soon becomes absorbed.—*Prescription.*

### Coffee versus Digestion.

Prof. Schutz-Schutzenstein, an eminent German scientist, has recently completed some interesting experiments in relation to the effect of tea and coffee on gastric digestion. He found that an artificial gastric juice was able, in eight hours, to digest ninety-four per cent. of coagulated egg albumen. When tea was added, other conditions remaining the same, only about sixty-six per cent., or two-thirds as much, of the albumen was digested; and when a decoction of coffee was mixed with the digesting albumen, only sixty-one per cent., or less than two-thirds, of the albumen was digested. The result was believed by the Professor to be due to the influence of the tannin upon the albumen. The effect was found to be less in proportion as the infusion of coffee or tea was weaker, and the conclusion was expressed by the experimenter that the deleterious influence of these common beverages is due not to the thein and caffein which they contain, but to the constituent tannin, the suggestion being made that an infusion made by pouring boiling water upon the tea or coffee and allowing it to stand for a few moments, instead of boiling for some time, is less deleterious in consequencee of the extraction of a smaller quantity of tannin.

This conclusion is doubtless correct, but it is equally true that an infusion thus made contains a smaller amount of thein and caffein. These substances are less easily soluble in water than tannin, and consequently the less injurious effect of the lighter infusions is not due to the fact that they contain less tannin, but that they contain less of all the poisonous properties contained in the tea leaf and the coffee berry.—*Modern Medicine.*

### Pyoktanin in Diphtheria.

Horing (*Memorabilien*) refers to the treatment he adopted early last year in twenty-seven cases of diphtheria, the results of which were published in the *Aerztl. Memorabilien*, vi. and ix., 1892. Since then, Horing has continued to use pyoktanin, and claims excellent results. The practice was to apply a 3 per cent. solution two or three times daily to the pharynx and downwards to the epiglottis, the retention of the liquid in young children being secured by immediately placing their heads low, thus aiding the swallowing of the liquid. Otherwise the drug was not administered internally, nor was it directly introduced into the affected tonsil. Simultaneously the patients are syringed with lime water, or are allowed to use it as a gargle or inhalation, while salicylate of soda is given internally.

When the nose is affected, a tampon soaked with the solution is retained in the cavity, and in milder cases the application of pyoktanin to the pharynx, etc., is the only treatment followed. In support of his practice, Horing says he has found even a 1 in 1,000 solution to destroy the Klebs-Loeffler bacillus, as also the more active streptococcus, the latter in the course of half a minute. In practice, the local effects are antiseptic, healing and destructive to the false membrane, the general results being diminution of pain and pyrexia without the production of toxic symptoms. The present cases enumerated are 112, two of which succumbed for reasons explained; the remaining 110 cured cases included many serious cases which had been despaired of. The symptoms, spread of contagion, and sequelæ, are quoted in support of the diagnosis. The author, in view of his experience, supported by that of others, regards pyoktanin as a specific against diphtheria.

### Treatment of Biliary Lithiasis.

In cases of acute hepatic colic, Grasset advises:

1. Place the patient in a full, warm bath, where he should remain from three-quarters to one and a half hours.

2. Give every hour, or even every half hour, a teaspoonful of:

℞ Sat. chloroform aq..... 150 grms.
Dill. water..... 100 "
Syr. orange..... 50 "

Or, chloroform may be inhaled and morphia given subcutaneously.

If olive oil is tolerated, 200 cc. may be given in wineglassful doses every quarter hour.

The food should be cold soup or milk, or ice cream. Injections to produce liquid stools should also be used.—*Times and Register.*

### Treatment of Chronic Gastric Ulcer.

Stepp (*Therap. Monatsh.*) describes a method which he has successfully followed during the last four years, the object of which has been to prevent fermentative changes in the organ with their damaging influence on the gastric walls, and, further, to exert a beneficial and tonic action on the damaged surface. This he has effected by the frequent use of a ¼ per cent. aqueous solution of chloroform, with the addition of subnitrate of bismuth, the latter, however, being of secondary importance. The water is given in quantities of one to two bottles daily. The author says chloroform has no anodyne or narcotic properties when administered internally, its effects being more those of an astringent, a tonic, and an antiseptic. A few cases are recorded showing how early the patients became convalescent under this treatment. When vomiting or hematemesis complicated the affection, the author found the chloroform acted effectually in quenching thirst, and arrested nausea and hæmorrhage. A burning sensation, probably at the seat of the ulcer, is always produced at first, but disappears completely in eight to ten days. No unpleasant consequences occurred, but indirectly a clean tongue and improved appetite seemed to be produced. At the end of the second week beef-tea could be administered, during the third eggs, and afterwards selected meats could generally be added to the preceding foods.

### Notes on the Physiological Action of Ozone Preparations

Dr. W. G. Thompson draws the following conclusions respecting the effect of ozonizing agents when given by the stomach or injected directly into the intestines or the blood. The experiments were made on dogs.

1. When injected in the circulation in full strength, *i. e.*, fifteen volumes per cent., they have a very destructive action upon the blood, ultimately having the effect of reducing rather than of oxydizing agents for the tissues.

2. Acting through the stomach or intestines, they may similarly affect the blood, and in addition they destroy the gastric and intestinal mucous membrane.

3. Given in medical doses by the stomach, their only benefit, if any, consists purely in their local action in the alimentary canal, in possibly preventing abnormal fermentations.

4. If so used, care should be exercised, owing to the great variability in strength of different preparations.

5. Ozone is of no real value to the tissues, whether inhaled or drunk in fluid preparations, and it may be exceedingly harmful.

### Simple Cure for Hiccoughs.

"I was just about to send a cure for hiccoughs to the New York man whose case has been puzzling the doctors, when I read that he had been cured by laughing heartily at a colored man's description of what seemed to the patient a most ridiculous cure," said a Pittsburg physician. "You hear of numerous cures for hiccoughs, such as holding your fingers in your ears and having some one give you a drink of water, holding one's breath for a period, etc.; but I doubt if any will stand the test as well as a practical cure, which for twenty years has never failed me once in all the hundreds of cases I have tried it. It may seem just as ridiculous as the cure proposed by the colored man in New York—so ridiculous that many will not think it worth while to try; it is nevertheless a sure cure:

"All you have to do is to lie down; stretch your head back as far as possible; open your mouth widely; then hold two fingers above the head, well back, so that you have to strain the eyes to see them; gaze intently upon them and take long, full breaths. In a short time you will be relieved of that troublesome hiccough.

"Now I have tried that sure cure on all sorts of cases, from the simple form to the chronic, and it works well with all. I remember it was given to a man on the way to New York to consult a specialist on his case—one of six months' standing—and it cured him in a few minutes. He turned around and said: 'What do you charge for that?' 'Nothing,' was the reply, 'except that you publish it to sufferers.'"—*Charlotte Med. Journal.*

### Protoplasm up to Date.

Protoplasm was formerly described as a homogeneous structureless jelly, but it is now clearly proved to be of various kinds, differing in each organism, and in different animals. It is of very complicated formation; a more or less delicate network of interwoven fibers forming the basis, and a clear watery fluid permeating its meshes, to soften its solidity. These fibres are strung with infinitesimal granules, which move to and fro along their length, aad their activity seems to be perpetual. They are apparently without structure, but they are supposed to vary in their composition, and to be capable of even minute subdivision.

Protoplasm cells contain, besides the clear protoplasm, a nucleus (which again contains minute fibres, fluids and granules), and also a compound called nuclein, in the form of dots, granules or rods, variously arranged, and it is frequently found enclosed in a tubula. This nuclein contains all the properties of the whole protoplasm, and in many instances all the essential characters of the animal or plant to which the particular cell belongs, and probably all the hereditary characters which the plant may transmit to its offspring.—*Times and Register.*

### On the use of Bromide of Potassium and Salicylate of Sodium in Headache.

Dr. Brunton, in *Practitioner*, first alludes to the fact that absorption from the stomach frequently ceases entirely during a headache, and drugs given by the mouth have then no effect. The only treatment in such cases is

morphine, hypodermically; but the possibility of establishing the morphine habit must be kept in mind.

He estimates that 80 to 90 per cent. of all headaches are due to defects of vision, uncorrected hypermetropia, myopia, astigmatism, inequality of the focal distance of the two eyes, and imperfect convergent power; 10 per cent to decayed teeth; and about 5 per cent. to disorders of the nose, throat, ears, scalp, and other causes. Headache due to visual defects is generally frontal, temporal, or occipital; but in one case recorded in the paper it was about 2½ inches below, and one inch to the right of, the occipital protuberance. In those cases associated with unequal visual power of the two eyes, it frequently affects the side of the weaker one.

A very common form of headache begins with unwonted irritability at night, which, however, is not always present. The patient wakes at four, five, or six o'clock in the morning, but feels disinclined to move, turns over, and goes to sleep again. He again wakes at seven or eight o'clock, with a distinct, but not severe headache, which increases as the day goes on, becoming very severe in the evening, and culminating in vomiting, which is followed by relief. If, however, he gets up when first waking, he generally escapes. These headaches may frequently be prevented by taking pot. brom. grs. $\frac{30}{3}$, with sodii salicyl. grs. $\frac{10}{3}$, in a tumblerful of water, when the feeling of irritability appears in the evening, or, in the absence of that, when waking early in the morning; and this may be repeated once or twice.

The two drugs combined act much better than either of them separately.

Dr. Brunton concludes his paper by contrasting our present armament of treatment of headache with that of twenty years ago; for whereas then we had slight power over them, now we are able to cure or relieve nine out of ten cases by attention to the eyes and teeth, and the use of bromides, salicylates, antipyrin, phenacetin, exalgine, and other remedies synthetically produced.—Robert E. Lord in *Manchester Med. Chron.*

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### The Antitoxic Function of the Liver.

Professor Bouchard attaches great importance to the power of the liver cells to nullify the effects of the toxines manufactured in the intestines. The correctness of this has been corroborated by the experiments of Schiff, Heger, Roger, and others, who found that alkaloids injected into the branches of the portal vein were much less poisonous than when they were introduced into the general venous circulation. M. Pavlow has confirmed these results by a series of experiments of which I give a *resume.* If by means of a ligature placed on the portal vein, the blood is compelled to deviate from the liver and pass directly into the general circulation, poisonous symptoms appear, consisting of fever and nephritis with albuminuria. That this nephritis is not due to hypertension of the blood in the renal vessels is proved by the fact that no such kidney trouble is caused by the ligature of the inferior vena cave, although this manœuvre is productive of a greater tension in the renal vessels than the operation in question. A wound artificially produced in an animal whose portal vein has been tied heals very slowly, whereas a similar wound in an animal where the inferior vena cava has been ligatured cicatrises without difficulty. The conclusion is that when the blood is prevented from passing through the liver toxæmia occurs, which is solely due to the fact that the liver no longer plays a protective role against toxtines which are being continually fabricated in the alimentary canal.—*Medical Bulletin.*

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### The Diagnosis and Prophylaxis of Intracranial Complications from Ear Disease.

By P. M'Bride, M. D.—This is an interesting contribution to the literature of the intracranial affections which may follow disease of the ear. Those which he specially considers are (1) meningitis, (2) phlebitis of the cerebral sinuses, and (3) abscess. In dealing with the symptoms manifested by such patients, the first point to be attended to is to have a careful objective examination of the ear made. If a patient suffers from chronic suppuration of the middle ear, and at the same time shows evidence of intra-cranial inflammation, probability points to the former being the cause of the latter, and presumptive evidence of the connection of the two, as cause and effect, is afforded, if the history points to pain localized in the ear as having preceded more diffused headache. The common belief that perforation of Shrapnell's membrane more frequently leads to intra-cranial complications is not shared by him. In estimating the probability or the reverse of the extension of inflammation from the ear to the endo-cranium, much importance is attached to the presence or absence of fetor. The first manifestation of danger is almost invariably pain in the ear or over the mastoid, the latter, indicating the spread of the inflammation in an outward direction, being favorable in character. Pain in the ear is soon followed by diffuse headache, and vomiting may or may not occur. The preparation of an hourly temperature-chart is recommended, and if marked fluctuations within short periods, if rigors be severe and frequent, and associated with perspirations, septic thrombosis, usually involving the sigmoid sinus, may be suspected.

In cases of intra-cranial abscess, Dr. M'Bride depends, for purposes of differentiation, on pulse, temperature, and percussion tenderness, the two former being of the most importance. But, when all has been said, the diagnosis of intra-cranial abscess can rarely be arrived at with any degree of certainty.

In considering the question of prophylaxis, excision of the tympanic membrane and malleus, with or without removal of the

incus, opening of the mastoid antrum and Stacke's operation are specially discussed, and the difficulty of the question of when to recommend an operation is carefully considered.—*Edinburgh Medical Journal.*

### External Periostitis Suppurative following Acute Attical Inflammation.

The child, five years old, had had measles three weeks before onset of pain in the ear. On examination of the tympanitic membrane, the membrana flaccida was found to be deeply injected. Under treatment, the pain abated; but within ten days the cheek and front of the ear swelled, which, on examination was found to be due to an external periostitis near the junction of the bony and cartilaginous canal. The abscess which formed was opened in front of the tragus, the cavity washed out, and a portion of necrosed bone removed.—*Archives of Pediatrics.*

### Poisoning from Veal.

A German ppysician, Dr. Van Ermengen, recently investigated the cauie of an outbreak of gastro-intestinal inflammation involving fifty-six person, four of whom died. The suspected cause was the flesh of two calves. On investigation it was found that the calves, when killed, were afflicted with a sickness of some sort. Examination of a portion of the body of one of these animals, and of the liver, spleen, and intestines of one of the victims of the poisoning, revealed a germ closely resembling those known to be the cause of hog cholera.

### Leprosy not Hereditary.

The rapid development of this disease in the Sandwich Islands and in India, and the death of Father Damien, resulted in the establishment, by the English Government, of a Leprosy Commission to investigate this disease. They found that the first case of leprosy in the Sandwich Islands occurred in 1830,—sixty-four years ago,—since which time it has increased until at the present time there is one leper to every thirty healthy persons in the Sandwich Islands. There are at the present time more than 1000 lepers at the Leper Asylum on the island of Molokai. In India there is one leper to every 2000 persons. By careful inquiry, the Commission learned that of healthy persons who associated closely with lepers, eating and drinking with them, 700 in 10,000 became lepers. Even the earth trodden by lepers is found to contain the germs of this disease.

The Commission concludes that leprosy is not hereditary. They bslieve that the soil and air of India have become so charged with the germs of this disease that any person who is susceptible to it is likely to come in contact with it somewhere, at some time, and become infected by it.

Recent investigations seem to show a possible relation between this disease and tuberculosis, or what is commonly known as consumption. The germs of the two diseases are so nearly alike that it requires an expert to distinguish them; they do not differ more than do the germs of leprosy obtained from different localities.

### Diagnosis of Diphtheria.

Dr. Wethered recently reported to the London Medical Society the results of a study of twenty-six cases of diphtheria and sixteen of follicular tonsilites. The study was made by means of bacteriological cultures upon glycerine agar-agar in large test-tubes. The test-tubes were then placed in an incubator at a temperature of 73° C. for twenty-four hours, when the cultures were examined microscopically. In the sixteen cases of follicular tonsilitis, staphylococcus only was found. In the twenty-six cases of diphtheria the Lœffler bacillus was found in fifteen cases, streptococcus in three cases, and staphylococcus in eight cases.

### A New Role for Bacteria.

M. Tischutkin maintains that the so-called carnivorous plants are incapable of digesting albumen; but that their sole characteristic property resides in their ability to absorb albumen which has been digested by bacteria. These are the conclusions which he draws from a careful study of the subject:

"1. The disintegration of albuminous compounds by the secretions of carnivorous plants is due to the growth of micro-organisms, principally bacteria.

"2. Micro-organisms possessing the power of dissolving albuminous compounds always vegetate in the secretions of completely developed carnivorous plants.

"3. The disintegration of the albumen does not commence at the moment of the secretion of the fluid, but only after micro-organisms have developed in sufficient numbers in the secretion.

"4. The micro-organisms found on the leaves of carnivorous plants come principally from the air, though they may be derived from other sources.

"5. The name 'carnivorous' plants is to be understood in the sense that the plants only assimilate the products which the lower organisms have set free.

"6. The role of the plant itself is only to furnish a medium in which certain organisms may live and develop."

### The Problem of the Etiology of Menstruation.

There is an activity of interest now manifest in the perplexing problem of the etiology of menstruation. One of the most interesting papers presented to the profession within the year, was read before the British Gynecological Society by Christopher Martin, M. B. Edin., F.R.C.S. Eng., Surgeon to the Birmingham and Midland Hospital for Women. His title was "The Nerve Theory of Menstruation." We have not space to follow his very

interesting reasoning nor the process by which he arrives at his conclusions, but his opinion is as follows: "The position of the menstrual centre can at present, only be surmized, but there is reason to believe that it will probably be found in the lumbar enlargement of the spinal chord. This portion of the chord is intimately associated with all the pelvic functions. It has been proved to contain, in the human being, the centres (*a*) for micturition, (*b*) for defecation, ond (*c*) for erection and ejaculation. Experiments on animals have demonstrated that it contains a center governing the act of parturition. . . . And if the parturition center be found there, the menstrual center will be not far away. The center is certainly not in the pelvis. There are ganglia in the substance of the uterus, ganglia in the nerve plexuses at the side of the uterus between the layers of the broad ligament, and on the cervix is situated a large ganglionic mass, developed in connection with the utero-vaginal plexus, called the "ganglion cervicale uteri." If these ganglia have anything at all to do with menstruation, they are certainly controlled by a higher center.

### The La Borde Method.

Professor Coutenot (Besancon) was recently lecturing to his students on asphyxia, and, as a young girl had just died in the hospital from tubercular meningitis, the idea struck him to go to the corpse and give a practical lesson on the new method of treatment by traction of the tongue. What was his astonishment, as well as that of his assistants, when, after a few minutes, he saw the respiration returning, the heart beating, and the face becoming colored.

This phenomenon lasted three-quarters of an hour. Death really existed, but the reflex action of the bulb—a respiratory centre—had not totally disappeared, and the traction had stimulated the phrenic nerve to bring the diaphragm into temporary action.

Failure of this resuscitating method would appear to afford an indubitable test of death. —*Times and Register.*

### Recurrent Tonsillitis.

Dr. G. A. Leland, in the *Boston Med. and Surg. Journal*, describes a method of dealing with tonsils in recurrent tonsilitis. He divides the tissues between the crypts by knife, scissors, and hooks, removing the tabs of tissues, and painting the surface with iodine and glycerine (Mandl.) This operation is frequently repeated, and in the author's hands, is uniformly successful; it is especially of service when tonsilotomy is objected to. He describes two somewhat scythe-shaped knives, which are introduced at one and brought out at another crypt, cutting the tissues between. —*Ex.*

## SURGERY.

### A Case of Primary Tuberculosis of the Mastoid Process.

Dr. Herman Knapp, of New York, describes the case of a child, aged five, whose right mastoid and supra-auricular portion of the temporal bone were swollen, ulcerated, granulating, and discharging fœtid matter. Both auricles, meati, tympanic membranes and tympani were perfectly normal, as far as could be discovered by physical examination, and the hearing in both ears was unimpaired. This affection of the mastoid was only a part of a widespread bone-affection, as the child had a granulating ulcer around the left ankle and necrosed bone around both orbits.—*Archives of Otology.*

## OBSTETRICS.

### The Treatment of Uterine Inertia Without Drugs or Tonics.

Van Waters (*New York Medicat Journal*, June 24, 1893,) remarks that the beneficial action of a suppository in the rectum in constipation is widely known. He asks: Why should not the same good result follow the use of a suppository in uterine inertia, and what more ready and effective suppository could we have than the hand? Hence, when the case has so far progressed that we are satisfied it is time for delivery to take place and yet inertia has supervened, the hands should be rendered strongly aseptic by the use of water, soap and a brush, and afterward immersion in a creolin solution. Then, after the administration of a little chloroform, the hand, well annointed with vaseline, should be gradually and slowly introduced into the vagina. As soon as it has remained there a few minutes pains will commence and increase in severity, in some cases to such an extent that the hand has to be withdrawn. In those cases in which Van Wates has resorted to this procedure the results have been most gratifying.—*The University Medical Magazine.*

THE

# MEDICAL AND SURGICAL REPORTER.

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## ORIGINAL ARTICLES.

### RACHIOTOMY FOR SPINAL INJURY: WITH REPORT OF CASE.*

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The number of cases of this sort in which operative interference has been practiced is so small that it seems the duty of each operator to put on record the report of all cases occurring in his practice. Each additional case must prove of value in determination of the proper procedure to be adopted in cases in which there are symptoms referable to injury of the spinal cord.

The report here presented, while it does not contain anything new or extraordinary, serves to emphasize facts reported by other observers.

Chas. M., æt. 34, American, farmer, was first seen by me Sept. 19, 1893. Fourteen monthe ago the patient fell from a tree, a distance of about twenty feet. He struck between his shoulders, head foremost; the body then twisted violently toward the right side. The patient was, so to speak, jack-knifed.

Consciousness was not lost, but an immediate paraplegia supervened. Within two days a bed-sore appeared over the sacrum, which persisted for eight months. The paralysis involved both the bladder and rectum; the urine dribbling away constantly.

The pain and soreness from the immediate injury gradually passed away, leaving behind the paraplegia, incontinence of urine and rectal incapacity.

At the time of my first examination, the conditions above mentioned were found. There was total and absolute loss of sensation and motion of the lower extremeties, a constant dribbling of urine and rectal apathy. A projection over the region of the eighth and ninth dorsal vertebræ was readily apparent. The reflexes were all present and exaggerated. The legs were not atrophied or contracted. No reaction to either faradic or galvanic current.

The general condition was excellent, he being well nourished and of good color. He was able by means of a bar to raise himself from his bed into a rolling chair, and then to propel himself with ease. The girdle sensation was not well defined, although there was the suggestion of one present.

Aftor consultation with Drs. Comegys, Conner, Dandridge and Freeman, the patient was advised to have the parts thoroughly explored in order to ascertain the pathological condition present. At the same time, he was informed that the strong probabilities were against his receiving any benefit from the operation.

The patient readily consented to the proposed operation, so on September 28, with the assistance of Drs. Freeman, Mussey, MacMillan and Garmuly, and in the presence of Drs. Comegys, E. W. Mitchell, B. Stanton, F. W. Langdon, Geo. E. Jones, N. P. Dandridge, P. S. Conner and others. The operation was made at Christ's Hospital. After cutting through the skin and clearing the muscles from off the laminæ, the spinous processes

* A paper read before the Ohio State Medical Society, Zanesville, May 16, 1894.

were bitten off, a chisel was then used to effect an entrance into the spinal canal: this having been accomplished the arches were bitten away with a rongeur forceps. The arches of the seventh, eighth and ninth dorsal vertebræ were removed, and it was found that the seventh had been dislocated, being turned to the right, the eighth and ninth had probably been fractured, and the spinal cord had been caught between the dislocated seventh and the fractured eighth, thus producing an apparent disorganization of the cord for the space of about one-half inch. The dura mater was everywhere adherent to the bony canal. After these adhesions were separated, the dura was opened, and the cord found to be in apparently good condition above and below the pinched portion, but the structures of the cord seemed to be entirely absent from the pinched portiou described above. The portion under observation did not pulsate either before or after the operation. But a very small amount of fluid escaped when the dura was opened. The edges of the dura were not stitched together, but the muscles were sutered, anp then a separate (continuous) suture was used to draw the edges of the skin together. The usual dressings (dry) were then applied, and the patient returned to bed.

During the remainder of this day and most of the next the patient vomited excessively, apparently the effect of the ether. After this passed off, there was no unpleasant symptom.

The next day, (September 29), he complained of a drawing or constricting sensation in the hips. The urine was withdrawn by catheter every four hours.

October 6. Stitches removed. Union perfect.

October 16. At this date the patient's condition is very similar to that before the operation, except that he retains his urine for four hours without any passing away in the meantime, and the bowels move more easily than previously. He is now taking strychnia gr. $\frac{1}{30}$ three times daily, and is having daily massage for the legs and abdomen.

On November 3, he returned to his home. The paraplegia remained unchanged, the urine had become uncertain, sometimes being retained for four or five hours, and then again leakage would occur within a short time after the catheter was used. The bowels, he declares, move more easily and satisfactorily than at any time since the accident.

After this recital of the case it seems scarcely necessary for me to call your attention to the fact that the operation in this case was not productive of a cure, but I do wish to call your attention to the fact that a real benefit did occur in the urinary and rectal symptoms. This same fact has been noted by other observers, and as these are the symptoms which are most annoying to the patient, it seems to me that this improvement alone would suffice to recommend the operation.

I shall not inflict upon you a critical review of all the cases published under this head, but there are some points of exceedingly great interest which can only be brought out by comparison with other reported cases.

The question of the propriety of surgical interference in these (traumatic) cases is not at all a decided point. A second question, and to my mind an exceedingly important one, is *when* to operate after injury to the spinal column producing paraplegia.

In regard to the wisdom of operating in these cases there can be but one logical conclusion, *i. e.*, when other means have failed and the patient's general condition is such as to give one a reasonable assurance that the operation of itself will not prove fatal, then we should feel justified in resorting to active surgical intervention. From the literature at my command, and I have gone over this pretty thoroughly, one can not expect to accomplish much by operation; yet, from the fact that some few cases have been benefitted and because we cannot definitely tell the exact condition present in a given case, one should certainly make the exploratory operation and thus be convinced of the necessity or futility of further procedure.

When should the operation be made? At first blush it would seem probable that the proper time for interference would be as soon after the accident as possible, but experience has, I think, demonstrated the wisdom of postponing surgical intervention for a greater or less time according to the indications in particular cases. When paraplegia is an immediate consequence of the injury, it is probable that the damage done to the nervous elements

of the spinal cord is so great as to produce disorganization of that structure, and hence no operative measures will be successful in restoring lost function. It is true that the paralysis may be the result of pressure from a displaced fragment of bone, probably a small piece driven into the substance of the organ, but the strong probability is that we have to deal with a badly bruised or disorganized cord. For the former condition, rest and extension, or fixation, will accomplish all that rachiotomy can; for the latter nothing can be done.

Our colleague, Dr. Ryan, has reported an exceedingly interesting and suggestive case, illustrating the truth of the remarks relative to the method of treatment by rest, or at least by non-interference. This case is reported in the Lancet-Clinic for May 23, 1892, and briefly is as follows: A man fell from a telegraph pole and sustained a fracture of the dorso-lumbar spine. He had complete paraplegia, with the exception of some control over the extensors of the right toes. Retention of urine, constipation and atrophied limbs completed the clinical picture when he was brought to the hospital thirty-six days after the accident. He was treated with potassium iodide in large doses, the Paquelin cautery and extension in a plaster jacket. Recovery was complete.

Several important points are not stated in the report of this case, and the omission is undoubtedly due to the fact that the patient was not brought under Dr. Ryan's observation until thirty-six days after the receipt of the injury. The time of the supervention of the paraplegia is an important item bearing upon the nature of the spinal lesion. The result of the treatment in this case leads one to the conclusion that there was no organic lesion of the cord; the cause of the paraplegia was probably compression exercised by a blood-clot, which was subsequently absorbed.

An extensive quotation of cases is hardly necessary for the purposes of this paper, but a few in which operative measures gave relief would be appropriate in order to establish the line between operable and inoperable cases.

Rieder reports the case of a man who fell from a second story. Somnolence, paraplegia and anæsthesia of the lower limbs were present. The spines of the fifth and sixth dorsal vertebræ were prominent. Sixteen hours after the accident resection of the spines and laminæ was performed and the pressure upon the cord was relieved. Even at this early period the cord was somewhat softened. Six months afterward the patient had a slow, spastic gait, although the other symptoms were absent.

Weiss operated upon a man of 34, who had a dorse-lumbar kyphosis, the result of a fall; associated with this was paraplegia, paralysis of rectum and bladder. A month after the accident the arches were removed; the cord was bent; the dura was not distended and was left unopened. Immediate and permanent relief was experienced. The man returned to perfect health.

The quoted cases along with the one reported this evening, will, I think, suffice to call attention to the fact that the main importance of spinal fracture is, like fracture of the skull, the injury done to the nervous structures enclosed. Mere fracture of the spine is, of itself, no more important than fractures elsewhere. Injury of the spinal cord, providing there be more or less disorganization of the structure, is irreparable. August Weissman says, that, "nervous tissue once destroyed is never replaced," and the experience of physicians gives strong confirmation to this statement.

From these statements it is easy for us to arrive at the conclusion that surgical intervention in this class of cases can only be of avail when the spinal cord is structurally intact. The only difficulty in the way of giving us an absolute rule in these cases lies in the fact that our powers of diagnosis are not complete and perfect enough to positively state whether the cord is intact or not. Were it possible so to determine, a considerable amount of useless surgery might be avoided. As it is, we ought in every case, after the possibility of spontaneous restoration has vanished, give the patient the benefit of the doubt and accurately determine the condition of the cord.

Leaving out of consideration the above mentioned class, we still have a considerable proportion of cases in which compression is the condition present. This pressure may be caused in a variety of ways It may be due to hemorrhage, it may be bony, or it may be due to adhesions.

Theoretically it seems easy to diagnosticate hemorrhage; here we should have a gradually developing paralysis, it should not occur instantaneously; but an element of confusion arises from the fact that the patient may be so stunned by the fall as to be unable to say just when the paraplegia developed.

It seems to me impossible, with our present knowledge, to discriminate between bony compression and organic lesion of the cord. Undoubtedly the vast majority of actual nerve-lesions are the result of injury inflicted by the bony structures, yet it is undoubtedly possible (and reported cases prove their existence) to conceive of an injury sufficient to cause loss of function and not sufficient to interfere with the integrity of the cord.

For these compression cases rachiotomy should furnish relief, provided the compression has not been maintained so long as to cause actual degeneration of the cord. You will recollect that in the case reported by Rider, softening had occurred at the end of sixteen hours, and from the report we are led to infer that the spastic gait, from which the patient subsequently suffered, was the result of this softening.

Having, theoretically at least, divided these cases into the classes of operable and inoperable, the next, and most important, question is as to the time for operation. Should these operations be done as soon after the injury as possible, or are the best interests of the patients served by postponing operation until nature has been given a chance to repair the damage?

Rider's case would seem to prove that an acute, irreparable softening of the cord may take place within a few hours after the infliction of the trauma, while that of Weiss clearly proves that the cord may completely regain its functions even though subjected to pressure for a considerable period of time (one month). It is clearly evident that the variety and nature of the pressure is important. A pressure which interferes with the nutrition of the cord sufficiently to cut off the blood supply to a portion should be relieved at the earliest possible moment, lest the secondary condition be far more serious than the primary. Late removal of such pressure would be useless.

Compression from blood clots might be avoided by an early operation, or at least such compression could be much more quickly removed by the surgeon than when the process is left to nature. It seems to me that early operation is advisable in cases where there is the history of a slowly developing and gradually increasing paralysis. By means of an early operation all hemorrhage may be checked and the danger of compression from this source be reduced to a minimum.

A third advantage in immediate interference lies in the positive knowledge that would be obtained as to the exact condition present, and the prognosis could be much more intelligent. This point in certain cases is one of the very greatest importance to the patient and his family.

Prolonged compression could be obviated in every case by prompt operation and the danger from this source be avoided. Reported cases up to the present time are not very numerous, but those I have examined are not at all encouraging where the operation is undertaken at a late date.

On the other hand there are several valid objections which can be urged against early operation. In the first place a large percentage, (just how large I am unable to ascertain) of these cases die within the first few days following the injury, and were these cases operated upon the mortality following surgical interference would be very great, and the operation would have to bear the responsibility.

A second objection is the presence of shock, and shock is generally pretty pronounced in these cases. The additional shock of the operation might throw the balance against some patients who might otherwise survive the primary effects of the trauma. It seems to me that this same argument might be applied with equal force to any traumatism in which shock is a feature. This condition should be viewed in the same light in relation to rachiotomy as it is in regard to other traumatism. A danger in early operations, which would have had much more influence a few years since than it should have at the present time, is the danger of sepsis arising from the mushy condition of the parts, and also because of the anatomical arrangement of the structures invaded. This is a danger not to be treated lightly, but I feel that proper aseptic precautions will here, as elsewhere, prevent the introduction of septic matter; hence this danger, of itself, should not be

regarded as any contra-indication to the early operation.

The inability to clearly distinguish structures at an early period because of the conditlon of the parts is a more serious objection. The muscles and tissues will generally be found infiltrated with blood and more or less confusion from that source necessarily arises, but it seems to me the difficulties would not be insuperable: care and prudence would be required, but these every surgeon gives freely in every case.

It seems to me that it is perfectly legitimate to compare fractures of the spine with fractures of the skull; the conditions are very similar aud the dangers very nearly the same. In each case the gravity of the case depends upon the the injury to the contained organs, the fracture itself being of but little moment. What one of us would think of waiting to see whether a paralysis caused by a depressed fracture of the skull would disappear without surgical aid? What would be worse surgery than to allow the delicate nervous structure to be irritated and perhaps ruined by a pressure we could remove? And yet, if my comparison is a legitimate one, and I think it is, the same reasoning should apply to the spinal cord as is applied to the brain. It should be our aim and object to remove pressure from the spinal cord just as soon as possible after the infliction of the injury. Moullin advises early operation in those cases in which the spine is fractured by direct violence, and reserve late operation for those in which indirect violence of sufficient force to cause fracture of the spine and paraplegia, will have produced the paralysis through an irreparable injury to the cord. The case reported to-day proves this.

One point to be borne in mind, especially in those cases in which an early operation is contemplated, is the likelihood of other serious injuries than that to the spine being present. Of course error upon this point should be carefully guarded against by a careful examination of the body.

Phelps says: "Recent fractures and dislocations of the spine should be operated. The large mortality should not deter since cases that would surely die or recover hopelessly paralysed may be saved."

Moullin's Surgery says: "In cases of fracture by indirect violence the operation of trephining offers little or no hope. It is probable that in the majority of cases the cord is only subjected to momentary compression, but yet it is so reduced to pulp that recovery of function rarely follows. If it were possible to diagnose the persistence of compression and to relieve it by operation, the condition would be no better and the probability of recovery not in the least greater. This has been confirmed by actual trial in a sufficient number of cases; in fractures of this description the injury to the nerve structures is either so slight than an operation of such a nature is not justifiable, or so severe that it could do no good. In fractures by direct violence, on the other hand, the question is altogether different. The lamina of a spine may be driven in with just sufficient force to compress the cord, without destroying it; and if anything of the kind is suspected, the operation should certainly be performed at once. It has proved its merit. Still more is this the case with the cauda equina. The nerves that compose it may be compressed by displaced bone or cicatricial tissue, and although they possess a power of adapting themselves altogether unknown in the spinal cord, there are limits even to this; and if improvement does not take place, or if in a few weeks it begins to flag, it is open to argument whether it would not be better to expose the seat of injury and, if possible, release them."

From the literature upon this subject one readily comes to the conclusion that here, as elsewhere, circumstances alter cases, and that much care and nicety of discrimination is necessary before one can distinguish the operable from the inoperable cases. The nature, kind and manner of injury seem to be the deciding points for and against operation.

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**Prescription for Offensive Breath.**

℞ Tinct. myrrhæ.
Tinct. lavandulæ.....ää 12.
Glycerin,
Liq. sodæ chloratæ.....ää 20.
Infus. salviæ..... 250.
M. Sig. Use as a gargle.

℞ Thymol..... 0.3.
Ol. Menthæ..... 0.5.
Ol. caryophylli..... 1.
Tinct. rhataniæ..... 10.
Spt. cochlear..... 30.
M. Sig. Gtt. x in a glass of water as a gargle.

—*Southern Clinic.*

# COMMUNICATIONS.

## PERSONAL EXPERIENCE IN THE TREATMENT OF STRANGULATED HERNIA.*

JOHN ASHHURST, Jr., M. D., Philadelphia.

Looking over my records I find that I have operated on nineteen cases of strangulated hernia, and in addition have operated on two cases of irreducible omental hernia, not strangulated. I have, of course, seen a large number of cases where I have succeeded in reducing the hernia by taxis. I have not kept a list of these, but the number is at least as large, if not larger, than the number of those operated on. While the number of my cases may seem small in comparison with that reported by others, this very fact confirms the view which I have always entertained —that strangulated hernia is a rare affection in Philadelphia, and rarer in this country than in the countries of the old world, England and Ireland particularly. Although the cases are few in number, yet following the old maxim—"*Observationes non numerandæ sed perpendendæ sunt*"—It has seemed to me that it might be worth while to bring them before the Academy, so as to introduce the subject for discussion.

Of the nineteen operations for strangulated hernia, fourteen were for inguinal hernia, confirming what everyone knows —that inguinal is the most common form of strangulated hernia, and the one that most frequently calls for operation. One of these cases was in a child, operated on at one of my clinics, and at once removed by the parents, and the further history of that case I do not know. Of the other thirteen patients, ten recovered and three died. The deaths occurred in cases where a fatal termination might have been expected, and were not due to the operation. In one case the hernia had been strangulated for five days and the patient was a pronounced diabetic. He died of gangrene after the operation, dependent upon the diabetic condition and upon the prolonged strangulation. The second death occurred in a woman of seventy-eight years. The strangulation was very tight, and the bowel was gangrenous at the time of operation. Rupture occurred at the sulcus corresponding to the line of constriction, and death took place from exhaustion in the following twenty-four hours. The third death occurred in a man of intemperate habits, who had a hernia strangulated for thirty hours and who had been subject to forcible taxis before admission to the hospital. So forcible had been the taxis that it had resulted in rupture of the bowel in two places. At the operation the scrotum was found enormously swollen and black from effused blood. Twelve inches of the bowel were gangrenous, and the gut presented two openings. I removed the bowel and performed a circular enterrorrhaphy, but the patient died thirty-two hours afterward from cardiac failure, without evidences of peritonitis. It is evident that in none of these cases was the result in any way due to the operation.

Four times have I operated for strangulated femoral hernia, with three recoveries and one death. In the fatal case the patient died in a collapsed condition thirty-six hours after the operation. I have no particulars of the case, but there was no evidence of peritonitis.

I have had one case of strangulated umbilical hernia which terminated fatally. The patient was eighty years of age, and the strangulation had existed for a number of hours. The patient died of peritonitis, which, as we all know, is particularly apt to occur as a complication after umbilical hernia, incisions into the upper portion of the abdomen being more apt to be followed by peritonitis than incisions in the lower portion.

The youngest patient on whom I have operated was a child two years of age, with inguinal hernia. This case ended in recovery. The oldest patient was the woman eighty years old, with umbilical hernia, just referred to.

Among cases of special interest I would mention one of the inguino-crural variety,

* Read before the Philadelphia Academy of Surgery, May 7, 1894.

where the hernia after coming down through the inguinal canal does not pass into the scrotum, but turns up in the line of Poupart's ligament and passes outward along the groin. It is usually complicated, as it was in this case, with an undescended testicle. In this case the hernia had been down six days when I operated. I was able by taxis to reduce a portion of the tumor, but finding that there still remained a hard mass which could not be reduced, I thought it right to open the sac and determine the exact condition. I found that the hard lump was the testicle in a gangrenous state, either from a twist in the cord or, as seemed more probable, from the taxis which had been practised rather violently before the patient's admission to the hospital. I excised the testicle and the patient recovered.

I have operated in two cases of irreducible omental hernia. In these cases a tumor had been present in the tunica vaginalis for a long time, and while there were no symptoms of strangulation, the weight and bulk of the tumor gave great annoyance, and the patients were exposed to the risk of a portion of the gut coming down at any time. I therefore, felt justified in operating in these cases, cutting away most of the omentum after securing its neck between two ligatures.

The points of special interest in the treatment of strangulated hernia which I would suggest for discussion are, as regards the resort to taxis, its limitations and the aid to its performance, and then as regards operative treatment, the particular mode of performing the operation, more especially as regards the direction of the deep incision, in regard to which some difference of opinion prevails, and as to the advantages and disadvantages of Gay's method as modified by Fergusson, and as to the advantages or disadvantages of Petit's plan of operating without opening the sac.

*The limitations of taxis.* I feel obliged to say that while I have reduced a good many strangulated hernias by taxis, while I think that it should be the surgeon's first thought, and while if practised with care and skill it is a safe method and one which will usually succeed when resorted to in time, yet I must express my belief that in the hands of an inexperienced practitioner, who sees but few cases of hernia, taxis is an unsafe procedure. Under such circumstances, I think that the patient would sometimes be safer with the operation of herniotomy than with taxis, for herniotomy is not a very difficult operation and not very dangerous if performed with caution, whereas taxis, while seeming to be very simple, yet if employed with great persistence and force may lead to the most serious consequences. My own cases of herniotomy which resulted fatally had been mostly subjected to prolonged taxis. Taxis, therefore, I think has its limitations, and should be resorted to with great gentleness and with great caution, except in the hands of those surgeons who are sufficiently familiar with the anatomy and treatment of strangulated hernia to feel that they may use the method more freely and more systematically. It is, of course, known to the Fellows of the Academy that its founder, the late Professor S. D. Gross, maintained that very few cases of hernia required operation. He prided himself that he was able to effect reduction by taxis where others had failed; and such was undoubtedly the case. In the hands of a man like Professor Gross, taxis was a safe procedure, but in the hands of the ordinary practitioner I believe that the line of safety for the patient will be often found in herniotomy rather than in a prolongation of taxis.

It is scarcely necessary to say that when taxis is employed it should be done with gentleness and with system. The ordinary method of pushing at the hernia is very uncertain, and is not only apt to do harm but is almost sure not to do good. The rule that the last portion of bowel which has come down should be first returned is very valuable and should always be borne in mind. Then I find what I am in the habit of speaking of to students as a kind of conjoined manipulation, a very useful mode of applying taxis, and I think the safest. The neck of the sac is grasped by the thumb and fingers of one hand, while the other hand, spread out, exercises a combination of pushing and squeezing; and then by a kind of alternating movement, slightly relaxing one hand while with the other the pressure is increased, if the hernia is reducible at all, it will go up. If no gurgling is heard in a few minutes it is not likely that taxis will succeed.

As regards the *aids to taxis*, the older surgeons resorted to many modes of as-

sisting taxis, but in modern times surgeons have pretty much come down to two or three. Even the warm bath, which was much resorted to formerly, I think is seldom employed at present. At the Pennsylvania Hospital, our practice is to put the patient in bed, apply ice over the hernia, and give a moderate quantity of opium. When the resident physician is not able to reduce the hernia by gentle taxis, this course is followed until the surgeon has been summoned. It often happens that when the surgeon arrives he finds that the hernia has been reduced spontaneously or disappears under the slightest touch. If this fails, our rule is to administer ether and again employ taxis, and in this way the hernia can usually be reduced. Before administering ether we have an understanding with the patient that if taxis does not succeed then the operation is to be resorted to.

Another manipulation which is of great importance is to draw down the hernia a little before beginning the upward pushing movement, the object being to disengage the portion of bowel which is nipped by the source of constriction. The plan known as Seutin's I have never seen of avail, and I can hardly conceive of a case where it would be required in which it could be used successfully. This plan consists in endeavoring to introduce the finger or thumb-nail into the constricting ring, which is then stretched; this could be practised only in very thin persons, and where it could be done I think it probable that taxis would succeed without it.

With regard to *herniotomy*, the first question that will have to be decided is the extent of the external incision. Some operators make a large incision, extending over the entire length of the hernial tumor. Others endeavor to effect the operation through a very small incision, as in Gay's method. My own plan is to make the external incision three or four inches in length, and over the neck of the sac. As regards the particular method of making the incision, whether by pinching up the tissues, transfixing, and cutting outward, or by cutting down from without, I really think that there is no choice. My own practice is to employ the latter plan. Having gone through the skin and fascia, the surgeon, of course, takes up the tissues cautiously, dividing them on the director. The next question is to whether or not the sac shall be opened. I agree with the English rule, that where it is justifiable to resort to taxis it is proper to endeavor to reduce the hernia without opening the sac. I have often tried to do this, but have been compelled to open the sac, as the constriction has been in its neck. In making the deep incision the tip of the left forefinger should be pressed against the source of constriction and the hernia-knife passed flatwise; this is then turned in the proper direction and the deep incision made with a gentle sawing motion, assisted by pressure of the finger below. I am satisfied that the rule of the English surgeons, to make the incision directly upward in inguinal hernia, is the correct one. While in a certain number of cases the surgeon can say this is a direct, or this is an oblique hernia, yet in other cases the relation of the parts is so confused that he cannot be absolutely certain which form of hernia he is dealing with. In the one case the internal epigastric artery will be on the inside and in the other on the outside. The safe rule, therefore, is to make the incision directly upward and in the line of the long axis of the body. In femoral hernia the deep incision should be made upward and inward. It is only in this direction that we are safe from doing injury and certain to reach the source of constriction, this being where the falciform process and Gimbernat's ligament join. The only danger from hemorrhage when this plan is followed is from an abnormal distribution of the obturator artery. To avoid wounding this, a good plan is to adopt Mr. Erichsen's suggestion to blunt the edge of the hernia-knife by rubbing it on the handle of another knife, or as suggested by Dr. Wyeth, to keep the point of the knife firmly pressed against the pupis.

In umbilical hernia the safe line of incision is in the median line, and directly downward. The operation is apt to be followed by peritonitis under any circumstances; but I think that there is less danger if the incision is made in this way, on the general principle that wounds in the lower portion of the peritoneum are less likely to be followed by peritonitis than those above. In the case on which I operated the hernia was of long standing, but the strangulation was recent, from the protrusion of an additional portion of bowel. There I followed the judicious

rule of not attempting to reduce the whole hernia, which would have required an extensive dissection, but simply relieved the strangulation and returned the part recently protruded.

With regard to the method of dealing with the contents of the hernia, I think that all surgeons agree that if the bowel is healthy it should be returned, but that if gangrenous it should be left in the wound and a false anus formed. If a distinct sulcus is found I think that it is a good rule not to reduce the bowel, so that if it should give way the extravasation may be outside of the peritoneal cavity. As regards the omentum, I think that it is a safe rule to cut it away pretty freely. If it is perfectly healthy it is proper to return it, but if there is doubt it is safer to remove it.

With regard to after-treatment, I am sure that the safest mode is not to make any attempt to get the bowels opened. Some surgeons are in the habit of giving a dose of oil immediately after the operation, and some even before the operation; but this seems to me to be injudicious. I put the patient on the use of opium and belladonna for a few days, gradually diminishing the dose, and usually the bowels move spontaneously in five or six days.

The number of cases which I have brought before you is limited, but they represent a sufficient variety to perhaps be available for the discussion of some of the points suggested.

## NINE CASES OF CONTUSIONS AND SPRAINS OF THE BACK, WITH SPECIAL REFERENCE TO THE EARLY TREATMENT OF THESE INJURIES.*

HENRY R. WHARTON, M. D.,† PHILADELPHIA.

During my term of service in the Presbyterian Hospital in 1892, there were admitted to the surgical wards nine patients who suffered from contusions and sprains of the back, and it has occurred to me that a short description of the method of treatment, which I have employed with the most satisfactory results in this class of injuries, might be of some interest to the Fellows of the Academy.

CASE I.—J. P., aged twenty-eight, gardener, who was admitted to the hospital May 5,1892,received a blow upon the back in the left lumbar region from a heavy wooden tub, which caused him severe pain. An examination after admission proved that there was no injury to the spine, but there was intense pain upon pressure in the left lumbar region, and also severe pain upon motion. The patient's back was strapped with adhesive plaster, and two days afterward he was able to sit up with comfort, and he was discharged from the hospital on May 9th.

CASE II.—H. P., aged nineteen years, fireman, was admitted May 12, 1892, with the following history: While standing on the edge of the tender of a locomotive he slipped and fell between the tender and the station platform; the engine was moving at the time, and he was rolled between the tender and platform, being severely squeezed in the lumbar region.

Upon examination after admission, no fracture of the spine or pelvis could be detected, but the patient complained of intense pain in the back, was unable to stand, and suffered from retention of urine. The back was firmly strapped with adhesive plaster. Upon introducing a catheter, a large quantity of bloody urine was drawn from the bladder, and after this the patient passed the urine voluntarily, which was deeply tinged with blood for four days. The patient improved steadily, and was discharged from the hospital on May 27, being able to walk, but still having some tenderness in the lumbar region, this part being still supported by means of adhesive straps.

CASE III.—J. G., aged twenty-five years, steam fitter, was admitted on May 20, 1892. The patient stated that while boarding a moving train at Powelton

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†Surgeon to the Presbyterian, Methodist Episcopal, and Children's Hospitals, Demonstrator of Surgery at the University of Pennsylvania.

Avenue he was thrown against the milk platform, striking his back and shoulder. An examination, on admission, showed slight contusion of the shoulder and marked contusion and tenderness over the lumbar region. The patient was unable to walk, and complained of severe pain upon pressure and upon making any movements. The back was strapped, which gave great relief. The patient also suffered from retention of urine, requiring the use of a catheter. The patient was discharged in good condition on June 4.

CASE IV.—D. D., aged forty-three years, bricklayer, was admitted to the hospital on May 23, 1892. The patient stated that while standing on a platform sixteen feet high, laying brick, the wall was pushed over by a derrick and he was thrown to the ground, striking upon his back. An examination after admission showed marked contusion of back and shoulder, great tenderness upon pressure and motion, and some tenderness over the spinous process of one of the lower dorsal vertebræ. The back was strapped, which gave great comfort. The patient was kept in bed for a week, and was discharged on June 6, in good condition.

CASE V.—R. C. W., aged twenty-seven years, brakeman, was admitted to the hospital on May 28, 1892. The patient stated that he was knocked off the top of a car on which he was riding, and was thrown to the ground, striking upon his back. On examination there was marked contusion of the back in the lumbar region, tenderness upon pressure, and inability to stand or walk. The patient's back was strapped, which gave him marked relief, and he was discharged on June 30th.

CASE VI.—A. W., aged twenty-eight years, trucker, was admitted to the hospital on May 31, 1892. The patient stated that while moving a heavy slab or stone, it fell and struck him upon his back. An examination after admission to the hospital detected no fracture of the vertebræ, but there was great soreness and tenderness on pressure in the lumbar region. The back was strapped, and the patient was discharged from the hospital on June 3d, in good condition.

CASE VII.—J. C., aged nineteen years, iceman, was admitted to the hospital on June 12, 1892. The patient stated that he slipped while crossing the street, and fell, striking his back upon the curbstone. He was unable to walk, and was brought to the hospital by the patrol. Upon examination after admission it was found that the patient had great pain in the left lumbar region, but there was no evidence of fracture of the vertebræ. The back was strapped, which gave him immediate relief. This patient suffered from retention of urine, and upon evacuation of the bladder it was found that the urine was bloody. The blood disappeared from the urine in a few days. The patient did well, and was discharged on June 14th.

CASE VIII.—W. McN., aged thirty-five years, brakemen, was admitted June 22, 1892. The patient stated that in a freight wreck at Tacony the car on which he stood was thrown from the track, and he was thrown to the ground, striking upon his back. An examination after admission showed that he was suffering from contusion of the back and foot. The back was strapped, and the patient was discharged, in good condition, on June 25th.

CASE IX.—L. B., aged twenty-five years, was admitted to the hospital June 25, 1892. The patient stated that while standing on top of a freight car he was knocked off by the Spring Garden street bridge, and was thrown to the ground, striking upon his back. On examination after admission, he was found to be suffering from severe contusion of the back, but there was no evidence of fracture of the vertebræ. The back was strapped, which gave him marked relief. The patient also passed bloody urine. The patient did well, and was discharged on June 28th.

It will be noticed in the above cases that the lumbar-dorsal region of the back was the part most frequently injured, and this part seems to be that which was most commonly the seat of contusions and sprains. As regards the treatment of contusions and sprains of the back, I consider that rest in bed is a matter of the first importance, and in addition I have found that the pain and general discomfort of the patient is much diminished, and the time of treatment much shortened by having the back firmly strapped as soon as the patient came under observation. The strapping of the back is effected by taking strips of resin-adhesive or of rubber-adhesive plaster, 2½ inches in width, and long enough to extend half way around the body; these are applied so as to cover in

the back, one strap slightly overlapping the other, from a point just below the junction of the last lumbar vertebræ with the sacrum to the lower ribs. These straps were often removed at the end of two or three days, and the back was restrapped if the pain and tenderness still persisted. The straps were usually allowed to remain in place until the patient was up and about, without complaining of pain or discomfort in the region of the injury. In cases of severe contusion the straps often require renewal a number of times.

This method of treatment of contusions of the back was first called to my notice by Professor Ashhurst while serving as resident physician in his wards at the University Hospital, and since I have employed it I have entirely discarded the use of fomentations and stimulating lotions, which are generally recommended in the treatment of these injuries.

The treatment usually recommended in contusions and sprains of the back is warmth, frictions, stimulating liniments, anodynes, acupuncture, galvanism, and massage, and of these I think massage is the most valuable, employed after the acute symptoms following the injury have subsided; but in early stages of these injuries I am convinced that strapping will be found the most satisfactory method of treatment.

I have observed that the application of straps employed as above described is usually promptly followed by relief of pain, and the fixation produced allows the patient to move with more comfort, and I am very certain, after having now employed this method of treatment in a considerable number of cases, that the time required for the recovery of the injured parts is much shortened. It will be observed, by referring to the cases reported, that many of them were comparatively trivial injuries, and the patients recovered in a short time; but even in this class of cases the suffering is often very intense for the first few days. It will also be observed that Cases II, VII, and IX passed bloody urine for a few days after the injury, showing that the injury had been severe enough to produce laceration or contusion of the kidney. Lidell‡ in his very excellent article upon contusions and sprains of the back, speaks of the frequency or hæmaturia in these injuries when powerful blows have been delivered upon the lumbar or dorsal region of the back. The recovery, as far as I know, in all of the cases reported was satisfactory, except in Case IV. In this case the patient developed, some months after leaving the hospital, symptoms of traumatic neurasthenia, complaining of pain in the back and head, and vertigo, and brought suit against the contractor for whom he was working at the time of the injury. From what I heard of this case, and from the fact that when it was ascertained that the patient was doing his ordinary work, the suit was settled for a trivial sum, I am inclined to think that the symptoms developed were not severe, and might be classed as litigation symptoms.

In cases of severe contusion or sprain of the back when there is inability to stand or there is present great pain on motion, and where tenderness over the spine and a certain amount of fixation is present after the injury, I think there is too much tendency to attribute the symptoms resulting to an injury of the spinal cord or membrane, which injuries when unaccompanied with fractures of the vertebræ are extremely rare; whereas the injury resulting to the muscles, ligamentous structures, and nerves, with perhaps the renching and laceration of the vertebral articulations, is perfectly possible to account for the symptoms resulting, and I agree with Mr. Page, that many of these cases are well described by the term "traumatic lumbago."

As contusions and sprains of the back are injurious which are often followed by the development of symptoms which are described as traumatic neurosis, or traumatic neurasthenia, it seems to me that these are cases which should be carefully treated when they first come under the observation of the surgeon, for I am sure that many of these cases if so treated by rest and fixation for a short time would make more complete recoveries, and would be less likely to develop the symptoms above described. In cases of contusions or sprains of the back in which symptoms of traumatic neurasthenia develop, and which give rise to litigation, it is often difficult for the surgeon to estimate how far the original shock of the system following the injury is responsible for the symptoms presented. In many cases the

‡International Encyclopædia of Surgery, vol. iv., p. 700.

objective signs presented leave no doubt of the severe nature of the injury, while in other cases the symptoms complained of are mainly subjective in their character, and these are the cases which give rise to the most troublesome litigation. It is often difficult to decide whether the symptoms presented are merely assumed or exaggerated for fraudulent purposes, or whether, without any attempt to deception on the part of the patient, injuries trival in themselves may be unconsciously exaggerated, and be apparently productive of serious results. Although many severe injuries of the back apparently recover without developing such symptoms as have been described, there is no doubt that the element of compensation for the suffering and disability from the injuries received plays an important part in the exaggeration of these symptoms, and that expectancy may be justly credited with an important place in their exaggeration. In cases of serious disorder resulting from contusions and sprains of the back, often apparently trival, the symptoms developing are usually progressive in their character, and soon there will become manifestly marked objective signs, such as paralysis, disturbances of the reflexes, loss of electrical excitability, disturbances of the bladder, loss of flesh, sleeplessnes, etc., which place the existence of morbid changes beyond a doubt.

# TRANSLATIONS.

## HERNIA OF THE LIVER.

Dr. Kusmin—(*Berlin Klin Wochen*, 1893—44,) reports: the patient æt 28, female, sought relief for a painful tumor, located between the umbilicus and the scrobiculus cordis, 25 c. m. in diameter. A diagnosis of hepatic hernia was made and proved correct at the operation. The hernial sac contained a liberal amount of fluid and a portion (circular) of the left lobe of the liver incarcerated. Reposition after the needed enlargement of the hernial canal; radical operation cure. Seven months later no signs of return. The patient had never worn a corset, but always had tied her skirt bands very tightly. —W.

## SUCCESSFUL EXTIRPATION OF A NEW GROWTH FROM THE LIVER.

D. J. Rosenthal reports (*Gaz. Lekarska* 1893, No. 45): Patient, female æt 41; had noticed for some weeks a tumor in her abdomen, finding herself at the same time growing much weaker. An examination revealed a hard movable tumor below the navel about the size of a child's head; it seemed to have no connection with the liver or genital organs. An operation was decided upon. Trendelenberg position showed the tumor to be attached to the left lobe of the liver; it was hard, nodular, of a bluish-brown color, it was covered anteriorly by the gall-bladder; its size was about as large as the head of a two-year-old child. The gall-bladder was pushed to one side and the adhesions between liver and tumor gently separated. At this stage the operator was certain beyond a doubt that the growth had started in Spiegel's lobe. The swelling was brought out through the abdominal opening, an elastic ligature passed around the pedicle, which was further fastened to abdominal walls treated extra-peritoneally. The patient made a good and uninterrupted recovery; the growth examined microscopically proved itself to be a fibroid angioma.

† Translated for THE MEDICAL AND SURGICAL REPORTER by the translators W. A. N. Dorland, M. D., M. B. Werner, M. D.

**An Agreeable Salicylic Mixture.**

℞
Potassii acetatis..... ʒij.
Acidi salicyli..... ʒss.
Syrupi limonis..... ʒij.
Aquæ menthæ piperitæ..... ʒviij.

Sig. One tablespoonful every three hours.

—*Southern Clinic*

## THE TECHNIQUE AND RESULTS OF RESECTION OF THE STOMACH.

Dr. Kocher reports 6 cases performed during 8 weeks for carcinoma (2 Gastroenterostomies, 4 resections of the stomach,—all resulting in a primary union). In connection with the report of these cases he presents an exhaustive study of the different operations together with their ultimate results. The question regarding the operation of election (gastroenterostomy or pylorectomy), he answers, that, by careful and scientific improvement in the technique of resection a more probable radical cure can be achieved, than by the palliative operation. Gastroenterostomy however may afford much relief in advanced cases of carcinoma and also be of great use in many instances where structures due to cicatricial or fibrous tissue exist, and in these last mentioned cases the preferable operation owing to inaccessibility of the pylorus often made more so by abnormal adhesions. The author then describes his method of operation—he follows Hacker rather than Wolfler—known as the gastroenterostomie antecolica anterior; the upper loop of the jepeinum is attached to the stomach in its transverse diameter, permitting the tube to have its natural position, the upper end above the lower end below. In uniting the stomach with the intestines great care should be exercised that the intestine is opened transversely on its convex surface. The ultimate results of gastroenterostomy, when done for carcinoma, has given the patient never more than one year, more often less; while on the other hand resection of the pylorus proved more successful. Wolfler has reported an interim of five and-a-quarter years; Billroth, two and-a-half and one and-a-half years; Rydygier, two and-a-half years, while the author's patient at five years and four months is still enjoying good health.

The author has operated on sixteen cases; in two of these he followed the method set forth by Billroth, gastroenterostomy, followed by resection of the pylorus; in nine other cases he excised the carcinomatous pylorus, first fitting the duodenum into the opening of the stomach. Two patients of this number died from the effects of the operation; one survived ten months and died from carcinoma of the liver. There was no trace of any recurrence. The remaining six cases recovered from the operation without any unpleasant symptoms, and are still living and enjoying good health.

The author names his operation "pylorus resection," with gastro-duodenostomy, and describes his operation as follows: A median incision (10 to 15 cm.) beginning a little above the umbilicus and extending downward, care being taken to excise the navel and arrest all hemorrhage, all adhesions carefully separated, and the tumor drawn out and clamped, two clamps at the duodenal and two at the gastric end of the tumor; the growth is then excised. The assistant then grasps the stomach behind the clamps, between index and middle fingers of both hands; the operator then cuts through close to the clamps, the free edges of the stomach are united and closed by the continued Lembert's suture and dropped.

The assistant again takes hold of the stomach with both hands, directing its posterior wall toward the right and anterior.

The clamp is still allowed to remain on the duodenum while its posterior surface is sewed (a continuous suture) to the posterior wall of the stomach; the clamp is then removed from the duodenum, its edge trimmed properly, an opening made into the stomach corresponding to that in the duodenum, and the anterior edges of both organs united, after cleansing the field of operation, the stomach and intestines are dropped, and the abdominal wound closed.

The important features necessary to insure a successful result, are as follows:

1. The operation must be strictly aseptic in all its details.

2. The continued suture is of the utmost importance, (Rydygier Lauenstein), the suture enclosing the entire thickness of both stomach and intestinal walls, thereby avoiding absolutely all secondary hemorrhage. The suture material consists of fine silk.

3. Kocher considers the use of the clamps of great importance, because they tend to simplify the operation, and aid in excluding the carcinomatous tissue. Another point which he makes in their favor is that they act as a guide in making a *straight* cut.—*Centralblatt of Chirurg*, No. 10, 1894.

—W.

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SATURDAY, JUNE 23, 1894.

## EDITORIAL.

### THE WOMAN IN SCARLET.

The REPORTER is led to make these remarks by observing an anachronism contemplated in a modern community. It is a serious proposal to gather figs from thistles and grapes from thorns; to harvest public good from the lava beds of public vice. All that is deemed necessary is to turn up the ashes and cinders of the social evil with that antiquated crooked-stick plough, licensed regulation.

Ignoring all past experience, the Board of Public Safety of Louisville, Ky., desires to try its hand at moderating the evil by licensing and regulating prostitution. It is precisely the plan that has been so often tried with an inevitable result in failure. In one respect it appears possibly an improvement on previous experiments, in so far as it proposes to devote all sums accruing from the licensing of disorderly houses to the maintenance of a home for fallen women. A moment's consideration of this feature, however, shows it to be specious if not ridiculous. We doubt very much whether the people in Louisville can thus be reconciled to giving legal sanction to immorality, especially as the whole plan is based upon a conceded failure.

In the United States there has been but one prominent experiment in this line. A four year's trial of the system in St. Louis, Mo., proved it such a colossal failure, that it was gladly abandoned. A similar attempt, but on a smaller scale, has been made in Cleveland, with the usual result of increasing the evil sought to be diminished. But in Europe the system has been most thoroughly tested over a number of years, with the positive conclusion that the licensing and regulation of prostitution has in no wise diminished the number of prostitutes, and on the other hand has apparently been responsible for the marked increase in venereal diseases. In England the system was abandoned as a failure after a most careful study of the subject in all its phases. On the Continent, the plan is still nominally in force, but indications are that it is on the point of being abandoned there likewise.

It is not our intention to discuss the

question in all its bearings, but simply to call attention to that part of it which relates especially to the medical profession. It will be observed that the most weighty reason urged in establishing every system of restricting or regulating prostitution, has been the assumption of its necessity as a sanitary measure. The burden of responsibility for the influence of this assumption rests with the medical profession. In the practical treatment of prostitution, it is impossible to separate the physical from the ethical and social elements of the condition to such an extent as to justify ignoring any one of the three in attempting to effect a cure. It therefore behooves medical men to be well posted on the entire subject before venturing to express an opinion or to advise any line of treatment.

Open prostitution is but one expression of the social evil. There are many who believe that if not created by the conditions which tolerate and perpetuate it, it has developed so that now these conditions actually necessitate it; and that it is impossible to eliminate this form of immorality and preserve intact those features of social life which are responsible for its existence. Social relations is a complex subject for study and discussion by the most thoughtful observers, and it has come to pass that a group exists of alleged reformers, who in literature love to be known as realists, whose business it is to stand on the verge of the abyss and, pointing out its many horrors, seek to convince humanity that salvation can be accomplished only by tearing down all the safeguards erected during a long existence of sorrow and struggle and, casting them in, fill up the bottomless pit. These realists generally exhibit the unfortunate conditions of human life truthfully. It is only when they attempt to draw logical conclusions from their incomplete premises, that they display a woeful incapacity to take a comprehensive view of life.

An eccentric Russian pessimist of this class, whose sincerity is much more trustworthy than is his judgment, has made a terrible presentment of the part taken by the medical profession in hastening the degeneration of mankind. The sentiments are worthy of the insane uxoricide into whose mouth they are put, but there is suggestion in them well worthy of the careful thought of all medical men. If not actually true, they might easily be made so, and the responsibility exists, whether they are true or not.

Tolstoi makes the dissolute Posdnicheff say:—

"True, there are ten commandents between the boards of the Bible, but they are only made to be recited before priests and tutors, and not nearly of as much importance as are the rules of grammar."

"So I have never heard my elders, for whose opinions I had a due respect, speak of concupiscence as a sin. On the contrary, I had often heard it boasted of. I was told that, once gratified, my passions would leave me in peace. I was told so, and I had read it in books. My elders said that health required it, and all my companions seemed to believe that it was something to be proud of. As to my danger of infection—that was the government's business—that point was guarded against. It regulates the concerns of the tolerated houses of prostitution. It assures the safety of debauchery to young and old. Salaried physicians are employed to guard us from the natural consequence of sin. It is all of a piece. We are told that incontinence is good for our health, and therefore prostitution is made lawful. Why! I know mothers who take care that their son's health should not suffer from too much virtue. Science itself canvasses for houses of prostitution."

"Science! how can that be?" I asked.

"Are not physicians the high priests of science? Who perverts young people by prescribing sexual intercourse? Who

teaches women to avoid having children? Who cures the guilty, when the sin overtakes them? The doctors! The priests of science."

"But why should we not succor the sick?"

"Because to cure the malady is to encourage its cause. It is on a par with all foundling hospitals."

"But—"

"If one hundredth part of the care was taken to cure sin, that is wasted to cure the sickness, disease would have died out long ago. All our efforts are devoted, not to extirpate debauchery, but to favor it by guaranteeing the safety of sinners."

And again, speaking of the doctors, this interesting lunatic says:—

"I neither like nor dislike them. They have ruined my life, as they have ruined the lives of millions before me, and I cannot help looking from the effect to the cause. I understand that they, like lawyers and other professional men, must make their living somehow, and I would have willingly given the half of my fortune, as others would if they knew as much as I do, on condition that they would keep their distance and not mix themselves with my affairs. I am not a statistician, but I know dozens of cases where doctors have killed, sometimes an infant in its mother's womb, on pretense she would die in childbirth (and, nevertheless, the same woman bore many children afterwards with perfect safety), sometimes the mother herself, under the pretext of a so-called operation. The world takes no account of these assassinations, just as it took no account of the cruelties and murders committed by the Inquisition, because they are supposed to be perpetrated in the interest of humanity. Innumerable as the stars of heaven are the sins of doctors. But all their crimes are nothing compared to the materialistic demoralization with which they poison the world through woman. I do not speak now of that materialism that refers everything to microbes and bacteria, and, instead of tending to the preservation of humanity, would lead to its dissolution. According to these theories, everybody should live in a perpetual quarantine, with a disinfecting pad under his nose, although, by the way, scientists have discovered now that even this is ineffective. But I will give them the benefit of the doubt. This supreme poison is the perversion of the human race, and, above all of woman.

"You can't say in these days, 'Your life is evil; reform it,' because doctors will tell you that the cause of evil is derangement of the nervous system, or a lesion of something somewhere. And you hurry to consult them, and, for a fee graduated according to their position in the profession, they will prescribe drugs from the apothecary, which you will swallow with a wry face. You get worse and worse; you consult another doctor; he will say the former treatment was all wrong, and will give you quite a new variety of nauseous doses, and your mind is relieved, and your body—well, never mind about your body."

A truly pessimistic nightmare, but a vivid relation of the powers and responsibilities of medical men.

Concerning the regulation of prostitution, medical men know that, no matter how faithfully carried out the provisions may be, all systems have so far proved unavailing. Where public prostitution temporarily appears to diminish, clandestine prostitution increases enormously. The attempt to prevent the spread of disease by the compulsory medical examination of registered harlots, is an utter farce. Statistics have shown us that under all systems thus far devised, immorality and disease have increased. The reasons are obvious without stating them.

Now if the Board of Public Safety of Louisville, is sincere in its desire to

restrict immorality and to prevent the spread of disease, and is not endeavoring to concoct some boodle scheme, we would suggest the invention of some new method, rather than wasting energy in making a new demonstration of an assured failure.

Destructive criticism is a very much easier undertaking than is the suggestion of something better to take the place of the subject criticised; but we think that a candid consideration of the methods heretofore unsuccessfully employed to mitigate the conditions complained of, will develop some of the reasons for the inevitable failure that has attended all efforts to restrict prostitution by regulation. The frank appreciation of the causes of the failure will naturally develop some suggestions for obviating them. The REPORTER therefore modestly offers to sociologists and professional reformers, an outline of a treatment for this unhappy disease, which is not copy-righted and the details of which can be made to suit varied requirements. As a system it would at least have the advantages of novelty, of producing a powerful impression, of rapidly crystalizing public opinion for or against it, while if it did not prove more effective than the older plan, it could not be a greater failure.

We submit that any authorities who would designate a certain locality as a centre and source of infection and would freely allow admission to and exit from that locality of all and sundry parties without any reference to their bringing to or taking from it an infectious disease,—as, for instance, cholera,—and yet would seek to protect the community against this disease by periodic examinations of the locality itself, to see whether infection was evident there—any authorities who would expect such methods to do else than assure the spreading of the plague, would confess themselves incompetents whose proper place is in the insane asylum. This is practically all that is attempted by any tried system for regulating prostitution by license and supervision. The so-called sanitary precautions undertaken have had for their sole object the protection of the male prostitute. It is true that the harlot may become a nidus of infection which will spread in all directions, but it must be remembered in her case, that the specific infection is not autogenetic; that it must be brought to her; that she is not the immediate carrier of infection who spreads it broadcast. Every experienced physician knows that the female prostitute may be capable of conveying infection of the most virulent type without exhibiting in her own person any indications of the existence of the disease. Furthermore he knows that there are multitudinous appearances which simulate disease but which are not of themselves infectious. Even where the indications of the disease may be present there are anatomical reasons making it extremely difficult to arrive at a positive diagnosis, unless the lesions are very pronounced.

Now comes the factor that has hitherto been religiously ignored. We are assured by those whose investigations render their statements authoritative, that, at the very lowest calculation, their exist for each female prostitute, four or more male prostitutes. Physicians know this to be true from their personal experiences in practice. They know that the detection of specific disease is relatively much easier in the male than in the female. They know furthermore, that it is the male prostitute that acts as the direct carrier of specific infection, and that upon his shoulders must be placed the responsibility for introducing disease to others entirely innocent, who must bear the disasterous consequences which ignorance entails upon specific disease neglected.

The gist of the whole matter is that to redeem the good name of preventive medicine in this particular field, protec-

tion must be given to the female prostitute, fully as efficient as that afforded to the male. If there is any good to be obtained by compelling the registration and medical certification of the female prostitute, by all means obtain it. But extend the regulation and supervision to the male prostitute as well, so that each may beware of the other.

A chimercial scheme truly, but one worth trying, if for no other purpose than to demonstrate its fallacy, and because on the surface it presents quite as much promise as anything thus far suggested in the way of governmental control.

We would therefore advise our Louisville friends to arrange matters in such a manner that something like the following may be put into effect:

At frequent, irregular intervals, make unexpected raids upon the disorderly houses. Place in custody all males found therein, without fear or favor. It is unnecessary to molest the females, who are supposed to be already under public supervision. Having arrested the male prostitutes, inflict such penalties in the way of fine or imprisonment as may be deemed desirable, or dismiss them with a warning; but under no circumstances whatsoever should they be discharged until they have been PHOTOGRAPHED in addition to the ordinary memoranda of identity. Next in importance to securing the photograph would be the compulsory submission to a thorough medical examination. Should no evidence of disease be observed, discharge the prostitute with strict injunctions to present himself in person for medical examination at suitable intervals until the known period of incubation, starting from date of arrest, shall have passed. There will be no trouble about these subsequent examinations when the prostitute learns that a failure to undergo them would entail the exposure of his photograph as a warning to the public that the original is to be ragarded as a possible source of infection, and, therefore, a menace to the community. If at the end of his period of observation, the individual is found free from infection, his photograph and all memoranda obtained by the health authorities may be returned to him without any violation of privacy.

Should the prostitute, at the first examination, display evidence of disease, he should be subjected to quarantine measures of more or less severity. In mild cases, perhaps, the display of his photograph in the offices of the Health Department and in the various disorderly houses, would be sufficent. At any rate, some such method would afford prostitutes of the other sex efficient protection by enabling them to immediately identity probable carriers of contagion.

The key to the whole business lies in the photograph and its skillful manipulation.

It must be understood that we are suggesting measures that would prove effective from the standpoint of public health alone. We do not pretend to say what effect such methods would have other than as sanitary precautions. The effect of putting some such scheme into operation can be better imagined than described; but we venture to say that three such raids made effectively, and the quarantine measures enforced without fear or favor, would settle the question of *public* prostitution in any city in America.

This plan is barely suggested, but it opens up possibilities for the effective treatment of the social evil that are not contemplated in any of the measures that seek to conserve the public health by supervising a small fraction of the individuals afflcted with the disease.

Make the measures rational, or cease prating about the sanitary necessity of regulating prostitution.

# SOCIETY REPORTS.

## PHILADELPHIA ACADEMY OF SURGERY.

*May 7, 1894.*

Dr. Ashhurst read his

PERSONAL EXPERIENCE IN THE TREATMENT OF STRANGULATED HERNIA.

See page 876.

DISCUSSION.

DR. JOHN B. DEAVER: I cannot add anything to what has been said by Dr. Ashhurst. I would ask the experience of the Fellows with reference to anastomosis. I believe that anastomosis operations are of value in but few cases of strangulated hernia. I have tried the method more by way of experiment, but the cases have not recovered. In order to do this operation it is necessary to pull down additional bowel. As Dr. Ashhurst suggests, where this sulcus has formed it is better to allow the bowel to remain in the wound or, as I prefer, to cut it away. In hernia the condition of the patient does not warrant the procedure of anastomosis, and even under the most favorable circumstances the operation is anything but satisfactory.

I remember a case of strangulated femoral hernia on which I operated some years ago. The bowel was completely separated, so that I could not find the proximal end through the opening made in exposing the hernia. It was necessary to open the linea alba to find it. There was extravasation of feces into the peritoneal cavity; here I did an anastomosis, but it was not successful.

I believe that we all agree that it is unwise to move the bowels immediately after the operation for strangulated hernia where the condition of the bowel is questionable and where increased peristalsis would favor rupture.

DR. J. M. BARTON: Dr. Ashhurst has had better fortune with taxis than I have had. One reason is perhaps that I have not spent much time with taxis. I have so often found the bowel in such a doubtful state, even after short strangulation, that I feel much safer, if there is any question as to its condition, to operate at once under antiseptic precautions. In one case the bowel was entirely gangrenous eighteen hours after the violence that produced the strangulation.

As to the advisability of making lateral anastomosis immediately after removing gangrenous bowel, the condition of the patient rarely warrants any prolonged operation, and I think that the rule now is, in intestinal obstruction, irrespective of cause, to do nothing further than establish an artificial anus at the first operation. I have devised an instrument for use in these cases. It is a modification of Dupuytren's enterotome. It can be adjusted in a moment, and is intended to make an intestinal anastomosis, allowing the artificial anus to remain as a safety-valve. Since devising the instrument I have not had a suitable case in which to apply it.

DR. O. H. ALLIS: I think that we all agree in what has been said about the use of forcible taxis. I remember an instructive case operated on by Dr. Hearn. It had been sent to the hospital after severe and prolonged taxis had been used. The constricted portion lay in the hernial canal, and he was obliged to cut down on it at that point. It was impossible to pass a grooved director between the constriction and the gut, so firmly had it been wedged. In two other cases I have seen the gut driven back and forced between the peritoneum and some of the layers of the sac, and in that way while the physician felt that he had reduced it he had only masked the trouble and made it more certainly fatal.

With regard to umbilical hernia I would state that I have had there three cases and have never seen such a case die. I should be glad if the Fellows would tell us their experience with umbilical hernia.

DR. H. R. WHARTON: I think that the most difficult point to decide in the treatment of strangulated hernia is the question whether or not to put the bowel back when it shows the marked effect of strangulation. In many cases where there is not absolute sloughing, it is hard to decide whether or not a bowel whose nutrition is much impaired will recover. Within the

past ten days I have had a case of femoral hernia where the color of the bowel was very unfavorable. After dividing the stricture I noticed some improvement in the color of the bowel, and I put it back with some misgivings. The patient has progressed satisfactorily without rise in temperature.

Another point that I have observed is that in cases where omentum is present in the hernial sac and prolonged taxis has been employed, the bowel is not in as bad condition as where omentum is not present. I think that the presence of omentum may save the bowel from pressure.

A point which Dr. Ashhurst did not bring out, although I know that he is perfectly familiar with it, is the relative rapidity of the occurrence of dangerous strangulation in inguinal and in femoral hernia. In femoral hernia the strangulation is more dangerous in the same time than in inguinal hernia.

DR. RICHARD H. HARTE: I would ask Dr. Ashhurst's experience with Littre's hernia. I have seen two cases. One was brought to St. Mary's Hospital after prolonged taxis, and the hernia was supposed to have been reduced. The symptoms did not subside, and when I saw the case the man was dying. At the autopsy it was found that a small portion of bowel had been caught and was strangulated. The second case was seen at the Episcopal Hospital. In this case, too, operation revealed a small portion of the bowel which was caught and strangulated. These cases are apt to be overlooked until rather late symptoms of strangulation make their appearance.

DR. J. M. BARTON: In reply to the question of Dr. Allis, I have had six cases of umbilical hernia and have had the misfortune to lose two. A method of reduction that I have found successful, I think it is worth alluding to. In these cases, the strangulated bowel is invariably in the centre of a mass of omentum. The small knuckle of intestine is at the very base, and any pressure on the surface would be utterly useless. In a case of this kind, seen some time ago, I grasped the abdomen above and below the hernia and lifted the abdominal walls, actually raising the patient from the bed. At the second attempt this proved successful. I have employed the same method in another case with success.

I have had the misfortune to operate by Tait's method within a few weeks. The patient was a woman fifty years of age with well marked symptoms of obstruction. I examined all the openings, but did not find any hernia. I then made an abdominal section and found a small knuckle of bowel in the femoral opening. The extent of bowel caught was not more than three-fourths of an inch. The patient was quite fat, and in order to release it I had to prolong the incision over to the right side. The bowel was gangrenous, and in delivering it infection probably took place, the woman dying forty-eight hours later. There were no marked symptoms of peritonitis. For hernia I should not consider this operation for an instant, but I did not know the case was one of hernia. After delivering the intestine I put my finger in the femoral opening, and tried to feel it from the outside, but was unable to, owing to the amount of tissue over the femoral opening and the small size of the hernial sac.

DR. JAMES COLLINS: I have nothing to add except to mention a little manœuvre which sometimes succeeds after taxis has failed, and that is to put the shoulders on the floor and draw the hips up, making taxis in this position.

The youngest case on which I have operated was a child two years old. It got well. My oldest case was eighty-two years old. I have operated on a number of cases with success, with the exception of a few operated on at the German Hospital. In these cases the strangulation had existed for several days. I would emphasize the necessity of opening the sac. In one case where I opened the intestine, I found on drawing down the bowel, another band about the intestine. I have seen the same thing in other cases.

DR. WILLIAM G. PORTER: I would emphasize the point made by Dr. Collins as to the necessity of drawing down the bowel. I have seen two cases where the bowel in the sac was carefully examined and found all right and returned, and was immediately followed by a gush of liquid fecos. My explanation of these cases is that the strangulated portion had returned and a healthy portion of the bowel had come down.

DR. SAMUEL ASHHURST: I have seen a case like those referred to by Dr. Harte, and this prejudiced me against the oper-

ation without opening the sac. Taxis was employed and the tumor was reduced, but the symptoms did not disappear. The patient died, and at the post-mortem there was found a small portion of bowel still remained within the internal ring, not involving the whole lumen.

My experience has been that almost every case of hernia stands by itself. I do not think that I have seen a case which did not present peculiar features. It is this that makes hernia to me one of the most interesting subjects in surgery.

DR. THOMAS R. NEILSON: The question whether or not the strangulated bowel shall be returned is a very important and often perplexing one. I have several times been in doubt, but in all cases have returned the bowel after relieving the constriction, drawing down the bowel and searching for perforations, and noting that under bathing with hot water the color of the bowel slowly returns. Another guide is the preservation of the lustre of the peritoneal surface of the bowel. If the lustre is still present it is an evidence that the vitality is not entirely destroyed.

I have had two cases of Littre's hernia or partial strangulation of the bowel. One was in an elderly woman brought to the hospital after five days of the so-called obstruction of the bowel. The patient was practically moribund, but at the earnest solicitation of the patient I operated. The constriction was found at the internal abdomial ring, involving only a portion of the gut. The patient died shortly after the operation. The second case was in a young man with left inguinal hernia. The patient presented a tumor not larger than a large marble, exceedingly tender, with pain at the umbilicus and a tendency to nausea. I operated and found a Littre hernia of the small intestine, and the patient recovered. The possibility of the occurrence of this hernia should not be overlooked.

DR. J. EWING MEARS: I can report one case of umbilical hernia in which strangulation had existed for forty-eight hours and general peritonitis had supervened. I operated and made an artificial anus, but the patient died within twelve hours.

DR. O. H. ALLIS: I think the operation in umbilical hernia is no more dangerous than in femoral or inguinal hernia. Where the constriction has been prolonged, probably any form of hernia means death. From what I have seen of umbilical hernia, I maintain that if it is a favorable case it is as likely to get well as a case of femoral or inguinal hernia.

DR. JOHN ASHHURST, JR.: I think that Dr. Deaver is entirely correct in saying that in the majority of cases of strangulated hernia it is not proper to make an anastomosis of the bowel at the time of the herniotomy. Whether we should open the gut or resect a portion of it when gangrene is present, I think should be decided by the extent of the gangrene. If there is only a patch, it is sufficient to open the bowel; if a large portion is gangrenous, it is probably safer to remove it. In the majority of cases it is proper only to establish a false anus, which may be subsequently dealt with. The only exception is where the surgeon has reason to fear that the portion of bowel involved is high up in the small intestine, when so much of the bowel would be cut off from exercising its digestive function that patient would die of inanition, even if he should survive the immediate results of the operation. Under such circumstances, if the patient is in a condition to justify further interference, I think it better to complete the operation by uniting the bowel according to one of the methods suggested. In the case in which I removed twelve inches of the bowel and united the ends by circular enterorrhaphy, no extravasation occurred, and the patient's death did not appear to be due to the operation.

With regard to taxis, I had intended to refer to the view of Mr. Jonathan Hutchinson, a surgeon for whose judgment I have the greatest respect. It will be remembered that he has recently, in connection with the advocacy of abdomial taxis, as he calls it, in cases of intestinal obstruction, referred to the operation of herniotomy, and has maintained that the statistics of the London hospitals show that the operation is a very dangerous one. Therefore he urges a persistent and systematic resort to taxis. There is no doubt that a surgeon who approaches a case believing that it is never necessary to operate will be more likely to succeed by taxis than one who entertains the view held by many at the present time, that

taxis is almost certain to fail, and that it is therefore better to resort at once to herniotomy. The personal equation thus comes into these cases. In connection with this matter I should like to refer to a case which I recently saw at the Pennsylvania Hospital. An old man, extremely deaf and extremely obstinate, was brought to the hospital with a hernia that could not be reduced. The resident physician made a reasonable application of taxis, and failed. Then he put him under treatment with rest, cold and opium, and sent for me. I attempted taxis and failed. The patient positively refused to take ether or to submit to an operation. I then made another trial of taxis, pushing it further than I have ever done before and further than I liked to, and the hernia did at last go up, and the man went out happy the next morning.

As I said before, I have only once operated in umbilical hernia, and in that instance the patient died. It is seldom that operation is required in these cases, taxis almost always being successful. I think that the results of experience show that operation in umbilical hernia is more dangerous than in either inguinal or femoral hernia. I was interested by Dr. Barton's suggestion to aid the taxis in umbilical hernia by lifting the abdomial wall. The same object has been accomplished by Froumüller by applying an exhausted cupping-glass over the hernia, and Dr. Washington has recommended a similar procedure.

Dr. Wharton has referred to the state of the bowel. My rule is to pay a good deal of attention to its color, and I resort to the use of hot water to see if the color returns. The glossiness of the bowel is also of importance. If the bowel retains its natural lustre, it is usually safe to reduce it. If it is dull and lustreless, and still more if the tissues separate under the surgeon's finger, it is not safe to return it.

Reference has been made to the presence of omentum acting as a safeguard against injury to the bowel from taxis. The same thing is found where the sac contains serum. It was a clinical observation of the late Professor Joseph Pancoast that, when he opened a hernial sac and found a quantity of bloody serum, he felt that the patient was going to do well. In such cases the serum serves as a cushion to prevent damage to the hernia from the taxis.

Dr. Collins has referred to taxis with inversion. Before the days of anæsthesia this method was regarded as of great value, but, like other "adjuvants to the taxis," is, I think, now seldom resorted to.

Dr. Porter has spoken of the gush of feces that occurs sometimes when the bowel is reduced. This, I believe, is due to the sudden "letting on," as it were, of the peristaltic stream, rupture occurring at the sulcus which marks the point of constriction. In all cases, therefore, it is important to make a thorough examination of the bowel, and, if a sulcus is found, not to effect reduction of the part which has been constricted.

Reference has been made to the persistence of symptoms after reduction. In such cases, I think that it is the generally recognized rule that the sac should be opened and an attempt made to bring the hernia down again. If this cannot be done, it would be right to extend the incision upward, which I think would be safer than making a median section. The same rule applies where there are symptoms of strangulation and a hernial sac is, on exploration, found empty.

Dr. Harte and Dr. Neilson have both referred to strangulation of a portion of the calibre of the bowel, often spoken of as Littre's hernia, but more accurately designated as Richter's, Littre's being a hernia of one of the natural diverticula of the gut. These cases are apt to be overlooked, and abdominal section for these partial herniæ has therefore been resorted to, the same operation having also been practised for obturator hernia. In some cases it is impossible to recognize the existence of a hernia, and under such circumstances abdominal section might properly be employed; but where hernia in any particular position is suspected, I think that it will be advisable to open and explore at this position, rather than to begin with abdominal section.

Dr. Wharton has spoken also of the relative dangers of delay in femoral and in inguinal hernia. Femoral hernia will not bear temporizing, and taxis should not be tried with the same persistence as in inguinal hernia.

Dr. Wharton presented

A REPORT OF NINE CASES OF CONTUSIONS AND SPRAINS OF THE BACK, WITH SPECIAL REFERENCE TO THE TREATMENT OF THESE INJURIES.

(See page 879.)

DISCUSSION.

DR. JAMES COLLINS: I regard the method described as ideal with one exception. My habit has been to suspend the patient and then fix the back, not necessarily to lift him up, but simply to make the back straight. I regard this as necessary to make the treatment ideal.

DR. JOHN ASHHURST, JR.: I have often resorted to this mode of treatment. Where the condition is one of contusion rather than of sprain, I commonly apply lead-water and laudanum, or some similar fomentation, until the superficial tenderness has passed away, and then apply strapping. In sprain or partial rupture of the muscles of the back, the immediate application of straps or of some other means of securing complete rest is all that is required, but where there is a positive contusion there is, I think, advantage in first using anodyne fomentations for a few days.

DR. RICHARD T. HARTE: I have seen many contusions of the back at the Pennsylvania Hospital, the force often being received over the ribs and transmitted to the vertebræ. In these cases I think that there is a certain amount of synovitis and arthritis between the end of the ribs and the vertebræ. In all these cases treatment by strapping gave immediate relief. If the patients are allowed to go without treatment they often go from bad to worse and have a long convalescence.

DR. JOSEPH HEARN: It might be of interest to refer to the diagnosis between lumbago and sprain in the back. If a person sprains his back he goes about his work for an hour or two without any discomfort, but when he takes a rest he cannot get up. In lumbago the pain comes on suddenly and continues.

DR. WHARTON: I have had no experience with suspension, as I have been satisfied with the use of straps.

In cases where there was contusion with effusion of blood I formerly used lead-water and chloride of ammonium lotion, but in my recent cases I have resorted to strapping, even when this condition existed. In these cases the patients experienced relief, and the pressure probably limited the effusion of blood.

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BRAIN TUMOR, PROBABLY TUBERCULAR IN CHARACTER, IN A CHILD SEVEN YEARS OF AGE, TREATED WITH LARGE DOSES OF IODIDE OF POTASSIUM — 103 GRAINS GIVEN DAILY FOR A PERIOD OF THREE MONTHS, WITH MARKED IMPROVEMENT IN ALL OF THE SYMPTOMS.

DR. J. EWING MEARS presented a patient for examination whom he had seen in consultation with Dr. Charles A. Groff. The patient, aged seven years, exhibited the symptoms of a brain tumor which was thought might be operable. Eye-examination by Dr. Oliver confirmed the diagnosis, but located the tumor in the posterior portion of the base of the brain. In view of the result obtained by this examination, it was deemed advisable to try the curative effects of large doses of iodide of potassium, given in gradually increasing quantities; 103 grains daily were finally administered with decided amelioration of the symptoms and without any ill effects from the use of the drug.

The history of the case is given by Dr. Groff as follows:

Elsie E., aged seven years. First came under observation in December, 1892. Complaining of severe headaches, happening almost daily and lasting for hours, during which the child was compelled to lie down until sleep came to her relief, apparently as the result of exhaustion. This had existed for two years, gradually becoming worse.

*Family history:* Father, painter by trade, was never sick in his life, never had syphilis, mother strong and healthy; no knowledge of having been sick.

There is a younger child, now less than two years old, born with equina varus, which difficulty has been almost entirely corrected by the use of splints and bandages.

Examination of patient at the date mentioned developed at once defective vision and slight paralysis of the right side, especially of the lower extremity. She was put upon bromide of potassium and was sent to an ophthalmic surgeon, who treated her for some time, but no

improvement in vision was noted, nor were the headaches lessened. She was sent to a second ophthalmic surgeon, who diagnosed a brain-tumor and said that nothing could be done for her.

In February, 1893, she was put upon iodide of potassium, six grains daily, which was gradually increased until August, when she was taking thirty-three grains daily. At this time the headaches had lessened in frequency, the condition of paralysis remained stationary, but the difficulty in vision seemed to be increasing.

Dr. Mears saw the patient on August 7th, in consultation. He agreed with me in the diagnosis, also in the treatment, and advised the increase of the iodide of potassium. This was done, ten grains being added to the daily dose every two weeks, until the child was taking one hundred and three grains daily. This point was reached in November, 1893, and was continued until February, 1894, when the amount was decreased to ninety grains daily, which quantity she has been taking up to the present time. As the remedy was increased, there was evident improvement in the condition of the patient. The headaches were much lighter in character and happening with markedly increasing intervals, until now they have practically ceased. The paralysis is much less marked, and Dr. Chas. A. Oliver, who has made repeated examinations, says her vision is improving.

Appended is the report of Dr. Oliver showing changes occurring under the administration of the large doses of iodide of potassium.

*Opthalmic examination, September 26, 1893.* Neuro-retinitis of a soft œdematous type, the left nerve-head being the more swollen; both the retinal arteries and the veins reduced in size, especially the latter; the left iris fails to respond to the strongest light stimulus; the right iris seems to respond at times; vision of right eye reduced to a doubtful light-perception in all portions of a considerably contracted field; vision in the left eye still further reduced to a faint recognition of light from the temporal side. These ocular conditions, with a general history of the child, gave a diagnosis of brain-tumor with enlargement of the ventricles; the supposed neoplasm being probably tubercular in character and situated in the posterior portion of the base of the brain (cerebellar?).

On October 18, 1893, there appeared to develop a doubtful left homonymous hemianopsia; the nerve-heads shrinking. No tubercular deposits could be recognized in any part of the fundus of either eye.

The irides gradually and interchangeably bettered in their reactions, the fields of light perception obtained both subjectively by the patient's recognition of the position of the light and at times objectively by the movement of the irides, until at the present writing they seem to respond much more freely than when the patient was first seen. Vision, which is reduced to perception of light, varies extremely upon different examinations, though relatively it is slightly better than when the patient was first seen; the examination at the last visit reversing the comparative areas of recognition in the right and left fields. Ophthalmoscopically, the nerve-heads are considerably shrunken and have become markedly atrophic.

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## A Rare Case of Incarcerated Umbilical Hernia.

A. Ciechomski reports that a patient, æt. 58; female; suffering from symptoms of incarceration for seven days; During this time the patient and family had repeatedly refused the operation which he had advised. At the end of this period contrary to his expectation, the incarcerated loop slipped back into the abdomen, aided no doubt by an accidental fall out of the bed, there was an immediate amelioration of the symptoms as also an arrest of the secundary symptoms of sceptic peritonitis. Fourteen days later however, acute perionitis set in, which ended fatally.—*Gazette Lekarska* 1893, No. 47.) — Translated by M. B. Werner, M. D.

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### Diphtheria and Membranous Croup.

The formula recommended by Dr. James R. Leaming is:—

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|---|---|
| Ammon. muriat. | ʒiij. |
| Potass. chlorat. | ʒj. |
| Aq. cinnamomi | ʒij. |
| Syr. acaciæ | ʒij. |
| Syr. senegæ | ʒj. |

M. Sig. Give one teaspoonful every five minutes until there is relief, or until vomiting ensues.

—*Prescription.*

# CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES for June contains a paper by Dr. Edward L. Keyes on

**Nephritis in its Surgical Aspects.**

The author sees no use in sterilizing or borating glycerine or vaseline as the results of some experiments instituted by him show that these will keep for years without becoming the lodging place of bacteria of any kind except the harmless air species. In regard to the constant use of the catheter in the prostatic enlargement of old men the author finds that the following rules have served him best. "A rubber catheter is kept constantly in a 1 in 4000 bichloride solution and washed in very hot water after each use. Simple glycerine is the lubricant. The anterior urethra is to be flushed as the catheter enters for the first time, and all the way in through the membranous and prostatic urethra, with a 1 in 4000 bichloride solution. The urine is to be entirely but very slowly drawn off (watching the pulse), the patient being recumbent. The bladder is then to be immediately washed out with a 1 in 1500 (sometimes 1 in 2000, if the stronger causes too much pain) nitrate of silver solution, which usually occasions moderate tenesmus. The bladder may then be washed out with a six per cent. salt solution (heaping tablespoonful to the quart), this to be drawn off, and such quantity of a weaker salt solution (teaspoonful to the quart) introduced and left as the surgeon may think best."

"The clean catheter, taken out of its bichloride solution and rinsed in hot water, and the salt solution, are to be used as often as any catheter is called for—further urethral flushings being a matter of personal judgment—the nitrate of silver being repeated every one, two or three days." In this way, the author states, the catheter may be used as often as necessary without infecting the kidneys and often without the presence of pus in the urine, and this goes on till the tissues have becomed hardened, when a non-disinfected catheter may be used, if simply kept clean.

When an operation is required, pus is generally already present in the urine. The author's routine practice here is to flush out the bladder and entire urethra before the operation with a salicylic acid solution followed by a 1 in 3000 or 4000 bichloride solution (after the anæsthetic has been given), and to follow the operation by a flushing out with a nitrate of silver solution, 1 in 1000; finally, and in subsequent washings for cleanliness, using about a six per cent. solution of common salt in hot water, and such strengths of the mercuric or argentic solution as seem called for. The author states that he has discarded boric acid solutions and Thiersch's solution on account of the difficulty of prompt preparation and because he has found the salicylic acid solution just as effective. Included in the paper are elaborate tables showing the relative germicidal properties of various drugs used to disinfect the urine either by the mouth or locally.

As the result of his experience the author comes to the following conclusions:

1. Healthy urine is sterile.
2. Purulent urine is always microbic.
3. Microbic infection takes place from within the body by a number of methods in the course of disease; it is often brought about by instrumental manœuvres on the part of the surgeon.
4. A healthy organism and vigorous bladder may cope successfully with microbic invasion, and rid itself spontaneously, or with a little aid, of all damage arising therefrom—showing little or even no inflammatory response.
5. A suitable condition of the patient's soil is essential to the propagation and perpetuation of inflammatory phenomena upon the urinary tract—after microbic invasion.
6. This condition, intensified by traumatism and physical weakness, notably of the degenerative variety, is most intense when there is vesical distention with atony, and when the ureters are dilated and the kidneys involved in the changes incident to tension below—namely, atrophy and sclerosis above, with or without surface catarrh.
7. Under these circumstances surgical pyelonephritis is most likely to declare itself as a result of microbic infection from below (occasionally from above)—in the course of suppurative disease or after operative interference.
8. Asepsis, antisepsis, and sterilization of urine are ends to be aimed at in genito-urinary surgery—but, like all other greatest goods, not yet attained in perfection. Much, however, can be done by local means in a prophylactic and curative way, little by internal medication, and possibly as much, or more than by any other means, by flushing the urinary passages with natural mineral waters.

A somewhat similar paper is that by Dr. George M. Sternberg on

**The Bacteriology of Pyelonephritis.**

After detailing the results of a number of experiments and quotting the utterances of various observers, he gives as his opinion that we are justified in including that cystitis and ascending pyelonephritis are usually caused by micro-organisms introduced through the urethra into a bladder which is rendered susceptible to infection by mechanical violence or chemical irritation. And that the most frequent cause of such local infection is the bacillus coli communis, which is constantly present in the intestine and upon the external surface in the vicinity of the anus,

from whence it may easily be transported to the interior of the bladder by catheters, etc., used by the patients themselves or by their medical attendants. But there is no evidence that the bladder is reached by the direct invasion of this or other bacteria without mechanical assistance.

Dr. Henry M. Lyman contributes a paper on

**Gastro-enteric Rheumatism.**

The painful paroxysms are experienced when the stomach is empty, that is several hours after taking food. The location of the pain is generally abdominal, usually occupying the epigastrium or the hypochondrium, possessing all the characteristics of neuralgia affecting the gaglionic nervous system rather than the cerebro-spinal nerves of the body. Rheumatic gastro-enteralgia exhibits a marked tendency to alteration with the neuralgias and myalgias that occur in other nerve territories. In this respect it conforms to the rule that governs the exhibition of vague, wandering, neuro-muscular rheumatism. The author then goes on to give the different diagnosis between this affection and the various other conditions for which it may be mistaken.

In the treatment, like other casses of intense neuralgia, the severest cases may require the palliative exhibition of an opiate, though the more ordinary cases are more easily relieved. When the period of distress occurs three or four hours after the last meal, it may be promptly arrested in many cases, by a crust of bread or a glass of milk, or a cup of hot water. The patient must, however, be cautioned against reliance upon such measures alone, for they sometimes aid in effecting dilatation of the stomach. Slightly alkaline liquids, such as lime water, are useful. When the gastric juice contains an extraordinary amount of hydrochloric acid it may be necessary to give sodium bicarbonate in doses of twenty grains, three or four times a day. Still better, because more curative, is the use of sodium salicylate or salol when the stomach will not retain the salicylate. The author recommends the patient taking a half ounce or more of salad oil whenever the stomach is empty. This also relieves the constipation that is so constantly present, and by liquifying the bile renders its discharge more easy and certain. In cases of obstinate constipation it is desirable to employ laxatives that stimulate the excretion of bile. The chronic character of the disease renders necessary a resort to alteratives in many instances. Small doses of mercury three times a day; potassium iodide with colchicum, together with tonic doses of quinine or of elixir calsayæ, must be administered for many months. Sometimes a course of nitric acid or of the ammoniated tincture of guaiac is very beneficial. Occasional mercurial purges should not be neglected and flushing the colon with hot water is often a means of great relief. The careful regulation of the diet is of the utmost importance. Elderly patients who are thin and neurotic often get help from small quantities of brandy or whiskey after meals, but this remedy is not to be taken habitually as arthritic subjects are very intollerant of alcohol. Debilitated patients who are easily exhausted, and who crave food at short intervals, should have a nitrogenous diet, with very little saccharine and starchy food. When fats disagree, they should be eliminated from the dietary; but when they are digested, they exercise a beneficial influence. Frequent warm baths give good results. Alcohol, tobacco, tea and coffee must be forbidden, for they are not compatible with arthritism, because they retard the processes of oxidation that need acceleration in every way. Great fatigue of mind and body must also be avoided.

Dr. J. Burney Yeo contributes a paper on

**The Management of Fevers,**

and particularly of typhoid or enteric fever. The author accepts the bacterial origin of the disease, and believes that a modification in the therapeutic conceptions and indications of specific fevers is therefore demanded. He also regards the antagonism of the pyrogenic and other poisons produced within the body by the micro-organisms which gives rise to these fevers as the most essential therapeutic indication to be applied in their treatment. In other words he is in favor of the "antiseptic" or "antitoxic" treatment of fevers of the specific type.

In the present paper he contends that already the results of clinical observation give promise of fruitful conclusions in the direction of obtaining effective agents for antagonizing the morbid activities of the infective or specific fevers, and that the average course and characteristics of such fevers can be favorably modified and controlled by such antagonists. As his experience widens he becomes more and more convinced of the practical values of such measures and of the practical necessity of continuing to work in this direction, so that we may improve upon our present resources, or develop them in greater perfection.

The author states that he has long been impressed with the great efficacy of a mixture known as euchlorine, and containing free chlorine, as obtained by the action of strong hydrochloric acid on powdered potassium chlorate. The mixture used by the author is made as follows: "Into a twelve ounce bottle put thirty grains of powdered potassic chlorate, and pour on this sixty minims of strong hydrochloric acid. A greenish-yellow gas is at once liberated. Close the bottle with a cork and agitate the mixture gently till the bottle is filled with the gas, then pour water into the bottle, little by little, closing the bottle and well shaking, at each addition, until the bottle is filled." Several antiseptics are here present in solution and therefore readily absorbable; free chlorine, hydrochloric acid, potassium chlorate, and probably one or two by-products. In twelve ounces of this solution he causes twenty-four to thirty-six grains of quinine to be dissolved, and some syrup of orange-peel added to make it more agreeable to take; and of this, in adults, he orders one ounce to be given every two,

three or four hours, according to the severity of the case. He has adopted this method of treatment in all cases of enteric fever with uniformly good results.

The effects of this treatment, according to the author, are:

1. There is a remarkable cleaning of the tongue and mouth. The aspect of the tongue in cases so treated is frequently quite unlike the usual tongue of enteric fever.

2. The foul, putrefactive odor of the feces is quite rapidly removed if the remedy be given sufficiently often and in sufficient quantity, for this fluid and perfectly soluble antiseptic certainly reaches and passes through the small intestine, as the nurses constantly report the odor of chlorine in the evacuations.

3. Another important effect of this treatment is a sustained depression of the febrile temperature—a continuously favorable effect on the pyrexia. The pyrogenic toxine seems to be under control, or continuosly neutralized, or excreted.

4. In certain cases, especially in young subjects, and if the treatment has been begun quite early in the case, the average course of the fever appears to be notably shortened.

5. There is another very striking effect of this treatment, and that is that the patients seem subjectively so much less disturbed by the fever poison. Their physical strength and intellectual clearness are far better maintained than by any other method of treatment that the author is acquainted with. In many cases the nervous system shows none of the signs of febrile intoxication that are so commonly seen. Finally, their convalescence is more rapid and complete, and troublesome squellæ, so far as the author's experience goes, are unknown.

The author states that the effect on the temperature is slowly developed, and it may take forty-eight hours before any notable effect on the temperature is produced. The temperature may actually rise a degree, or even more, in the first twenty-four hours of its administration, which appears to the author to indicate that the antipyretic effect is due to a general antagonizing influence on the pyrogenic poison in the tissues, rather than from any immediate or direct effect on the heat-regulating mechanism.

The author is of the opinion that nourishment in typhoid fever should be administered very dilute and only in such quantities as the patient can absorb. As to the use of stimulants, he believes that the general tendency is to give them too early and in too large quantity. They are needed, in moderation, toward the end of the most severe and protracted cases, but the less severe cases do better, in his opinion, without any. He has used, in association with moderate amounts of alcohol, in protracted cases with marked cardiac debility, infusion of coffee, with more marked and sustained stimulation of the heart than when alcohol alone has been given. He thinks those excellent cardiac stimulants, tea and coffee, have been too much neglected in the treatment of fevers.

The author is opposed to the use of the depressing antipyretics, and regards the cold bath as attacking a result of the disease only. He states that he has seen calamitous results follow its use, and as a routine treatment he emphatically condemns it.

**Apoplexy in its Relations to the Temperature of the Body,**

With a consideration of the qnestion of heatcedtres, is the title of a paper by Charles L. Dana, M. D. The following is a summary of the results reached by him:

1. That all intra-cranial hemorrhages, whatever their lesion, are much more apt to be accompanied with immediate disturbances of temperature than are necrotic processes from embolism and thrombosis. These temperature disturbances in hemorrhages are, in rare cases, a sudden initial fall, then, in almost all cases, except where the lesion is small, there is, within a day or two, a rise of temperature of from one to three degrees. On the other hand, in acute softening, this initial fall and early rise do not occur unless the process is very extensive or involves the pons.

2. In apoplexy due to hemorrhage, the temperature is greater upon the paralyzed side than on the normal, the difference averaging one degree. In acute softening, this unilateral difference of temperature does not occur, or is extremely slight.

3. The rise of temperature due to apoplectic lesions depends more upon the extent and nature of the lesion than upon its location. Lesions of a hemorrhagic character in the cortex, however, are especially apt to cause a rise of temperature. Lesions in the pons, also, either of hemorrhagic or softening character, almost uniformly cause a rise of temperature.

4. There is as yet no clinical evidence that lesions of the basal ganglia or the parts about them cause temperature rises on account of destruction of certain thermic centres; in other words, the clinical and pathological evidence of thermic centres in the human brain, aside from the parts mentioned, is yet inadequate.

The author urges the importance of a careful study of apoplectic cases in regard to the temperature changes. The temperature should be taken on both sides of the body and in the rectum if possible. With data thus gained one can, he feels sure, obtain much more positive evidence as to the nature of the lesion in these cases, and the author has repeatedly been able to satisfy himself, in his clinical work, of the nature of the lesions by means of the methods referred to. He does not believe that, with the help of the numerous factors which we now have in aiding our diagnosis, there are many cases of apoplexy in which it is difficult to make a diagnosis. The old time tabulation of differential points in diagnosis between hemorrhage and acute softening are valuable.

**The Abuse of Trachelorrhaphy**

is discussed by Dr. William R. Pryor in an able article. The question of the immediate closure of the cervix is not entered into in

the paper, which deals solely with the secondary operation. The author condemns those gynecologists who sew up the cervix in a nullipara for the same reason in both—the cure of sterility. In the one case the cervix is too stenosed, they say, and therefore the woman is sterile; in the other it is too open, and again she is sterile.

Retarded involution seems to him the result of other causes than a torn cervix and he is more inclined to attribute it to a protracted first stage of labor with the consequent fatigue of the uterine muscle, together with a poor general condition. Cystic degeneration of the cervix more frequently follows as the result of generous tears and the possibility of its occurrence is perhaps some slight argument in favor of the immediate operation. But its presence is a positive contra-indication to trachelorrhaphy. The most profound questions in connection with the histogenesis of epithelioma are suggested by these cases. They demand a very thorough removal of all the affected tissue, and not puncturing the cysts and trachelorrhaphy.

The author expresses his belief that in the effects of lacerated cervix, except to a very limited degree. In some women any form of peripheral irritation will establish a more or less severe degree of neuritis; and occasionally a cystic cervix will have such an effect. The removal of the affected tissue is here demanded and not its union by suture.

The author believes that cancer of the uterus is becoming more and more frequent, but he rejects the teaching that laceration of the cervix is the cause, and believes that the phenomena of development and involution incident to pregnancy are much more prominent in the causation of cervical cancer than are the tears which invariable follow labor. The great part which functional activity with periods of repose plays in causing cancer is well shown in the preponderance of mammary cancers in those women who have nursed. Women who have by heredity a tendency to cancer should remain sterile, inasmuch as repeated childbirths more than anything else conduce to it and disseminate it. If we operate to *prevent* the possible occurrence of cancer in those who may reasonably expect it, assuredly trachelorrhaphy is not indicated, but a more radical procedure which will remove the entire cervix.

A pathological laceration of the cervix, requiring trachelorraphy, he would define as any laceration which is of such severity and degree as to implicate the circular fibres of the cervix sufficiently to cause a modification in the shape or position of the uterus. A tear to do this must sever most of the sphincter fibres of the cervix at one or more points. The lesions found associated with the laceration of the cervix he deems best treated by either a currettage of the uterus or by some form of amputation of the cervix which provides for the maintenance of a cervical mucous membrane. And usually it is well to combine the two operations in conditions demanding the latter.

Trachelorraphy he would limit to the immediate operation for hemorrhage, and to those cases of tear through the cervix from internal os out to the vaginal junction, cases of true extra-peritoneal rupture of the uterus.

The great objections that he has to trachelorrhaphy are, that it does not give a cervical canal of dimensions equal to the requirements of a woman, who should, as she gets older, bear each successive child with greater ease and security than the preceding; it does not remove sufficient tissue where operation is indicated; and it does not appeal to him as a rational procedure, believing, as he does, that most of the cases subjected to it require no operation whatever on the cervix, inasmuch as a generous laceration is normal and necessary.

Dr. Florian Krug advocates

**Hysterectomy in Bilateral Disease of the Appendages**

for the following reasons:

The uterus without the adnexa is a useless organ, and devoid of physiological function.

It is not innocuous; it is, on the contrary, positively a diseased and therefore harmful organ.

Histologically, the tubes are but parts of the uterus, and their removal is partial amputation of the uterus; therefore, why should we not go a step further and remove the rest of the diseased organ?

Careful observation and questioning of his patients, he states, has elicited the fact that the artificial menopause is much easier for a woman who has had her uterus removed, whether for cancer, for fibroid, or when associated with disease of the adnexa, than when the tubes alone were removed. The explanation of this lies in the fact that when we remove the uterus we remove the great mass of ganglionic tissue in the organ. So far from increasing the mortality, he states that the mortality is lessened in the hands of those familiar with the technique of hysterectomy. In its performance it takes no longer than the admittedly proper procedure of curettage preceding a celiotomy, and some less than to attach a proper drain where drainage is demanded, or to do a hysterorraphy.

Dr. W. W. Keen contributes a paper on

**Amputation of the Entire Upper Extremity**

(including the scapula and clavicle) and of the arm at the shoulder-joint. The paper has a special reference to methods of controlling hemorrhage. The author reports on one case of the former and amputation and four of the latter. After detailing the various methods in use for controlling the vessels during the operation, the author states that he has adopted the following method, which may be called Weyth's method, as it is essentially an application of his hip-joint method to the shoulder. With the patient at the edge of the table with his arm held at right angles to the body, two sharp-pointed cylindrical pins eleven inches long and one-quarter of an inch in diameter near the head, are used. The anterior pin is introduced through the middle of the anterior axillary fold, (tendon of the pectoralis major) at a point a little nearer to the body than what may be called the centre of the fold transversely. The point of emerg-

ence of the pin is of much greater importance than the point of insertion; this should be an inch within the tip of the acromion. The point of the pin is protected, after being pushed through, with a piece of sterilized cork. The second pin is now introduced at a corresponding point through the posterior axillary fold (tendon of latissimus dorsi), emerging again an inch within the tip of the acromion. Some little care is needed to avoid striking the spine or the scapula. The exact point of emergence is important in order to avoid the objection that, if the pin emerges near or at the tip of the acromion, the moment the head of the humerus is removed the tubing is apt to slip downward, compress the two flaps against each other, and thus hide the cavity formerly occupied by the head of the humerus. The vessels may then retract and bleed freely in this cavity, and, being entirely inaccessible except by removal of the apparatus, will require ligation of the subclavian, or, if the tubing is removed, copious hemorrhage will follow before the vessel can be caught. The pins being placed in position, a piece of black-rubber tubing half an inch in diameter is then wound tightly around the axilla and shoulder on the hither side of the pins. It is important that this tubing should be the pure black rubber, which is very elastic, and not the far less elastic white-rubber tubing. The disarticulation having been completed, the main vessels and all other visible smaller vessels are tied and the tubing quickly removed. All other spurting vessels are then seized with hemostatic forceps. The author states that he has not troubled to remove the pins until after seizing the vessels, so little have they been in the way. The puncture made by the pins heals quickly, and is of absolutely no importance. The only object of the pins is to hold the tubing in place and keep it from slipping. The author feels quite confident that any one who will adopt the method in the manner described will abandon definitely all other methods in favor of this, except in emergencies, which, of course, are subject to no fixed rules.

For the control of hemorrhage in cases in which it is necessary to remove the arm, the scapula and the clavicle, the author advises that the subclavian vein and artery be tied, previous to amputation, by resection of the clavicle at its middle portion.

In amputation at the shoulder joint, in cases where the axilla is invaded so high that Wyeth pins cannot be used, the author follows the method of Delpech, which consists in making an oblique incision extending from the external third of the clavicle to an inch above the inferior border of the great pectoral muscle. The lesser pectoral can then be cut near to its origin on the coracoid process of the scapula. The index finger is then carried through the cellular tissue along the serratus magnus muscle, then the subscapular, and is used as a hook in order to draw outward the mass of vessels and nerves. The artery is always situated at the anterior part of the mass, is surrounded, and, as it were, indicated by the roots of the median nerve, and nothing is easier than to surround it with a ligature which will embrace nothing else. This process is preferable in that it produces but little injury to the parts, that it leaves a certain space between the ligature and the trunk, and permits temporary compression of the subclavian artery, above the clavicle, on the first rib.

The article is illustrated by woodcuts and photographs illustrative of the procedures referred to by the author in his paper. Reports of cases are also given.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## GYNECOLOGY.

### Menstruation and Ovulation.

From a rather extended histologic study, Leopold and Mironoff conclude that menstruation, i. e., the periodic discharge of blood from the uterine mucous membrane, is usually accompanied by ovulation, although the former not rarely occurs without the latter. The hemorrhage depends upon the presence of the ovaries and an adequate degree of development of the uterine mucosa, and not upon the maturation and rupture of ovisacs. Ovulation occurs, as a rule, at the same time as menstruation. The process requires an increased afflux of blood to the generative organs for several days, and results in the formation of a typical corpus luteum. Ovulation may also occur independently of menstruation, though under physiologic conditions but rarely. At times ovulation, with the formation of a typical corpus luteum, is replaced by an afflux of blood to an ovisac that has not matured and does not undergo rupture, resulting in the formation of an atypical corpus luteum. Normal ovisacs may be present at a time when the ovaries are undergoing senile contraction, and they may undergo physiological rupture and form typical corpora lutea.

## MEDICINE.

### Note on the Treatment of Warts by the Internal Administration of Arsenic.

Symson contributes an article on this subject in the *Quarterly Medical Journal.*

Though warts sometimes disappear spontaneously without any treatment whatever, and, although the treatment of them by various kinds of outward applications is often perfectly successful, yet quite enough cases

are found apparently intractable by ordinary methods to justify a short note on the use of a drug which seems specially adapted to cure this tiresome and vexatious complaint.

First, a word or two as to local remedies. The writer has tried on different patients, and occasionally the same patients, nearly all the drugs usually recommended for the abolition of warts. Such are glacial acetic acid, salicylic colloid, fuming nitric acid, carbolic acid, liquor potassæ and argenti nitras. The first two named in this list seem to act best, and the salicylic colloid he prefers of the two, as most easily applied by any unskilled person and least irritating to the patient.

But for the last few years, acting on a suggestion in an American medical journal, and on account of Mr. Pullen's paper (*Practitioner*, 1888, vol. i, p. 207), in every case of warts which did not show some signs of yielding to these applications in ten days or a fortnight, he prescribes small doses of arsenic internally. Of its rapid action on the warts there can be no doubt whatever. He has repeatedly tried it by itself, and by the end of a fortnight even a large crop of warts will have disappeared. An advantage, also, of its use alone is that by children (who are, of course, the chief sufferers from warts) any kind of caustic or painful operation is much dreaded; also, very little arsenic need be given. The drug need not always be given as long as a fortnight, for a week's treatment by small doses, twice a day, seems to set up a healthy action in the warts, which is continued after the medicine has been left off. The combined treatment, though, of arsenic internally, with salicylic colloid painted daily on the wart, is quicker than that by arsenic alone. The author gives one, two or three minims, either of the liquor arsenicalis or liq. arsenici hydrochlor., twice or three times a day, according to the age of the child, and has never found it needful to exceed the largest dose. He has never found any symptoms of its disagreeing with the patients.

Its action on the warty growth is no doubt due to the increased metabolism of the skin, leading to these hypertrophied portions being killed and exfoliated.

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### Muscular Rheumatism.

The following abstract in the *British Medical Journal* of an article by Leube is from the *Deutsche med. Woch.* in which he argues that muscular rheumatism is not a local disease, but a general infective disorder with special localizations in the muscular system. The mode of onset of the disorder varies, but is sometimes marked by shivering and prodromal fever, and by *malaise* of some duration. In some cases the muscular pains may be widespread, and occasionally endocarditis is observed. Taking a series of about 200 cases, he found that fever was present in about one-third; it was seldom higher than 102° F., and generally fell after two days in hospital either rapidly or after some irregular fluctuations. In one-sixth of the cases there was a cardiac murmur at the time of admission; it is generally supposed that endocarditis, which is so common a "complication" of joint rheumatism, scarcely ever occurs in relation with muscular rheumatism. It is not possible to say in how many of the cases in which a murmur was observed this was present before the onset of the muscular rheumatism, but it was noticed that in half the cases the murmur grew fainter or disappeared while the patient was under treatment, and that whereas in all the cases together fever was observed in one-third only, it was present in two-thirds of those in which there was a murmur. Moreover, in a few cases the murmur was observed to appear after the onset of the muscular rheumatism. Three such cases are related by Leube, but in one there was at a later stage muscular rheumatism, and in another the patient at the time the muscular rheumatism came on, was under treatment for gonorrheal urethritis, vaginitis, and cervical endometritis. Leube states that he has seen joint rheumatism come on after muscular rheumatism in several cases, and points out that muscular rheumatism is frequently observed after affection of the joints. Pleurisy was in a few rare cases observed as a complication of muscular rheumatism, but albuminuria only once. Leube concludes that it is highly probable that the infective material in muscular rheumatism is an attenuated form of the virus of acute rheumatic arthritis. In Wurzburg, where his observations were made, the cases of muscular rheumatism coming on at the clinic were, as a rule, few in number and isolated, but at one time recently a large number of cases applied, so that half a ward was filled with them; this would appear to indicate an epidemic influence. He only mentions the question of treatment incidentally, but would seem to have relied on salicylate of soda.—*N. A. Practimis.*

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### Special Exercise to Correct and Prevent Constipation.

Friction, rubbing or massage over all parts of the abdomen two or three times per day by the patient himself, or less frequently by a good magnetic operator, will help to promote vital action of the bowels. If not convenient for the patient to walk or ride for exercise, he can secure the advantage of both in large degree by the following exercise, taken in his room.

Standing with the feet well apart, to broaden your base, bend or flex the lower limbs at the knees and extend the same about twice a second, or one hundred times a minute, for several minutes at a time, three or four times a day, and at the same time twist or turn the body above the hips first to the right and then to the left as far as you well can, resting the hands upon the hips or allowing them to hang by your side. At each turn of the body toward the right or left you will bend the knees about three or four times. You thus use chiefly the flexors and extensors of the thighs and the rotating muscles of the trunk. The motion of the body is meanwhile up and down, and the

motion of the chest and head is alternately to the right and left. To facilitate the turning of the body, the heel of the limb opposite the one on which you rest, as the body sways from side to side, may be raised so as to allow the limb to turn upon the ball or toe of the foot. To get the best effect of this exercise, the head must be kept well up, the shoulders back and the spine erect during exercise. The bowels may generally be allowed to rise and fall with the body, but at times it is well to exercise the diaphragm by endeavoring to draw up beneath it the liver and viscera of the abdomen.—Dr. Dutton in *Jour. Amer. Health Society.*

### Rest in Heart Affections.

Dr. T. Lauder Brunton believes that as a remedial measure, rest frequently requires to be absolute; as a preventive one, it may be only relative. The amount enjoined must be carefully proportioned to each case, as in advanced mitral disease, when the power of the heart is failing, absolute rest gives satisfactory results, in that the circulation recovers its balance, the arteries become filled and the veins emptied, the dropsical effusion and venous engorgement of the organs disappear and the patient recovers a fair amount of health.

The philosophy of this is well known to medical men. In the early cases of valvular affections of the heart perfect rest may prevent the mischief extending, and, at least, will help the heart to recover itself. This is especially the case when there is any indication of heart disease in growing boys or anæmic girls.

In anæmic girls, however, gentle exercise is advisable, but it must be carefully graduated, as exhaustion is likely to do harm. Massage may be useful, as it gives the patient exercise without putting any strain upon the heart. With a fatty heart, gentle exercise may be advisable, as it may be more likely to bring about a healthy condition of the heart than absolute rest.

When in mitral disease cardiac tonics, even pushed to their utmost limit, fail to give relief, then absolute rest becomes of great importance. Massage is of great usefulness in clearing out the body-waste, quickening the flow of blood through the muscles and relieving the edena, and the patient gets the advantage of the exercise without overdoing his heart. It also allows the treatment to be carried out more easily than would otherwise be, for it removes the feeling of weariness and irritability, faintness and unrest of the patient.

## OBSTETRICS.

### Eleven Months Pregnancy.

Max Bensinger reports a case of eleven months pregnancy in a healthy woman 27 years of age, who had previously given birth to two children of normal weight and appearance, delivered at proper term. The child, a boy, was born alive after twelve hours labor without instrumental aid. He registered the abnormal weight of eleven pounds. The placenta was exceedingly large, and the amniotic fluid very scanty. This case has considerable interest from a medico-legal point of view, inasmuch as the courts in most countries accept 300 days as the extreme limit of pregnancy. If the husband of such a woman should happen to die during the first or second months of gestation it would not only blacken her reputation, but the child would be deprived of its rights of paternal inheritance, which might involve a large estate or even a crown. Hence the importance of physicians recording all cases of retarded pregnancy.—*Pacific Med. Jour.*

## ARMY AND NAVY.

### CHANGES IN THE U. S. ARMY FROM JUNE 3, 1894, to JUNE 9, 1894.

The following named officers, having been found by Army retiring boards incapacitated for active service on account of disability incident to the service, are by the direction of the President, retired from active service.

Lieutenant Colonel Samuel M. Hornton, Deputy Surgeon General.

Captain Marcus E. Taylor, Assistant Surgeon.

Captain William G. Spencer, Assistant Surgeon.

Upon being relieved from duty at Camp Merritt, Montana, by First Lieutenant William H. Wilson, Assistant Surgeon, First Lieutenant Edward L. Munson, Assistant Surgeon, will proceed without delay to Fort Yellowstone, Wyoming, and report to the commanding officer, for temporary duty with troops in the National Park during the season.

### U. S. MARINE HOSPITAL SERVICE FOR THE FIVE WEEKS ENDING MAY 26, 1894.

Murray, R. D., Surgeon; to proceed to Brunswick, Ga., for special duty April 30, 1894. To procced to Waynesville, Ga., as inspector, May 17, 1894.

Hutton, W. H. H., Surgeon; detailed for duty as Inspector of Quarantine Stations, April 27, 1894.

Hamilton, J. B., Surgeon; granted leave of absence for three days, May 14, 1894.

Gassaway, J. M., Surgeon; granted leave of absence for fifteen days, May 12, 1894. Leave of absence extended five days, May 26, 1894.

Stoner, G. W., Surgeon; to inspect Cape Charles Quarantine Station monthly, April 27, 1894. Granted leave of absence for thirty days May 18, 1894.

Godfrey, John, Surgeon; to represent the service at meeting of American Medical Association, at San Francisco, Cal., May 11, 1894.

Irwin, Fairfax, Surgeon; to proceed to Berlin, Germany, for special duty, May 5, 1894.

Carter, H. R., Surgeon; granted leave of absence for three days, May 3, 1894; to pro-

ceed to Key West Quarantine for temporary duty, May 4, 1894.

Banks, C. E., Past Assistant Surgeon; granted leave of absence for five days, May 1, 1894.

Carmichael, D. A., Past Assistant Surgeon; to proceed to St. Louis, Mo., for temporary duty, May 15, 1894.

Peekham, C. T., Past Assistant Surgeon; to proceed to San Francisco Quarantine Station for duty, May 17, 1894.

Glennan, A. H., Past Assistant Surgeon; to proceed to Wilmington, Del., for special temporary duty, April 25, 1894.

White, J. H., Past Assistant Surgeon; to inspect Quarantine Stations, April 29, 1894; granted leave of absence for seven days, April 29, 1894; granted leave of absence for twenty-three days, May 4, 1894.

Bratton, W. D., Past Assistant Surgeon; to report at Bureau, and then to proceed to Delaware Breakwater Quarantine for duty, May 19, 1894.

Magruder, G. M., Past Assistant Surgeon; to proceed to Key West Quarantine Station for duty, May 15, 1894.

Kinyoun, J. J., Past Assistant Surgeon; to proceed to Wilmington, Del., for special temporary duty, April 26, 1894; detailed as Chairman Board for physical examination officer, Revenue Marine Service, April 30, 1894; detailed to attend annual meeting State Board of Health, of North Carolina, May 11, 1894; to inspect property at Wilmington, N. C., May 14, 1894.

Woodward, R. M., Past Assistant Surgeon; to proceed to Chicago, Ill., for special duty, May 7, 1894.

Vaughn, G. T., Past Assistant Surgeon; detailed as Recorder Board for physical examination Officer Revenue Marine Service, April 30, 1894.

Stonel, J. B., Past Assistant Surgeon; to inspect Quarantine ports, April 26, 1894.

Perry, J. C., Past Assistant Surgeon; to assume command of service at Norfolk, Va., May 4, 1894.

Young, G. B., Assistant Surgeon; to proceed to Key West, Fla., for duty, May 15, 1894.

Brown, B. W., Assistant Surgeon; to proceed to Pittsburg, Pa., for duty, April 27, 1894.

Rosenau, M. J., Assistant Surgeon; to proceed to Boston, Mass., for duty, April 23, 1884.

Cofer, L. E., Assistant Surgeon; to proceed to San Diego, Cal., as Inspector, and to assume command of the service after June 30; April 26, 1894.

Eager, J. M., Assistant Surgeon; to proceed to New Orleans, La., for duty, May 16, 1894.

Nydegger, J. A., Assistant Surgeon; to proceed to Savannah, Ga., for duty, April 28, 1894.

Strayer, Edgar, Assistant Surgeon; to report for duty on Revenue Bark "Chase," April 28, 1894.

Oakley, J. H., Assistant Surgeon; to rejoin station San Francisco, California, May 16, 1894.

PROMOTIONS.

Assistant Surgeon G. B. Young, commissioned as Passed Assistant Surgeon, May 25, 1894.

Assistant Surgeon W. G. Stimpson, commissioned as Passed Assistant Surgeon, May 25, 1894.

APPOINTMENTS.

Arthur R. Thomas, of Illinois, commissioned as Assistant Surgeon, May 25, 1894.

Henry W. Wickes, of Maryland, commissioned as Assistant Surgeon, May 25, 1894.

Hugh S. Cumming, of Virginia, commissioned as Assistant Surgeon, May 25, 1894.

## NEWS AND MISCELLANY.

Dr. Emory Lamphear, for many years editor of the *Kansas City Medical Index*, has resigned the chair of Operative Surgery and Clinical Surgery in the Kansas City Medical College and has removed to St. Louis. He makes the change in order to become Professor of Surgery in the St. Louis College of Physicians and Surgeons, one of the oldest and strongest medical schools in the West.

Dr. C. D. Palmer, of Cincinnati, is receiving the congratulations of his many friends on the verdict in the malpractice suit against him, which was rendered in his favor May 26th inst.

In 1888 the doctor in making a perineal operation on a woman, broke his needle. Careful search failed to find the fragment either in the soft parts or on the floor. The patient was not doing well under the anesthetic and further search was deemed unwise and the operation brought to a finish. A few days after the doctor was thrown from his buggy in a runaway and received severe injuries about the head, remaining in an unconscious or semi-unconscious condition for about a month and being utterly unable for business for a year. In the meantime the patient fell into the hands of another physician who operated again and found the needle. The case was taken up by a couple of young lawyers whose time hung heavily on a contingent fee and fought desparately. The editor of the Cincinnati *Lancet-Clinic* used some strong language in regard to the young barristers in his journal. They went to his office with horsewhips and attempted to horsewhip the editor. They had miscalculated muscular force however and received the whipping themselves, after which they fled leaving their arms behind them. The editor went to the police court whips in hand and swore out a warrant for their arrest and had them fined for assault and battery. This aggravated the youths and made the fight more bitter. Dr. Palner is and has been professor of Gynecology in the Medical College of Ohio for a quarter of a century, and is on the staff of the Cincinnati and Presbyterian Hospitals. The doctor was ably defended by Judge Conner, brother of Dr. F. S. Connor. The amount sued was for $10,000. It has been one of the most malicious cases in court.

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## ORIGINAL ARTICLES.

### OBSERVATIONS ON TYPHOID FEVER.

JOHN M. CURRIER, M. D., Newport, Vermont.

Having seen thirty-six years of the practice of medicine has led me to change some of my views of typhoid fever, not only of its etiology but also of its pathology and treatment. Mercury in any form I do not employ, and beef-tea, once so popular, contains almost no nourishment. Patients who were fed on it starved so that they could not be resuscitated. Cathartics I seldom have occasion to use, and, on the other hand, if there is diarrhœa, I do not check it unless there are more than three evacuations a day, or unless there is much pain accompanying them.

I am not a microscopist, but I accept the theory of the microbe as the cause of typhoid fever; that it is introduced into the system through the alimentary canal in the food and drinks. The mucous membranes of the stomach and intestines are the first organs affected; next the glands of the intestines. In these last named organs is located the seat of the pathognomonic symptoms of the disease. I shall dwell on this part of the pathology of the disease more particularly than on all others, on account of its bearing on the treatment, and of the importance in sustaining the patient.

We often hear that mild cases of typhoid fever result fatally, and very unexpectedly too. Many of these cases undoubtedly could have been saved if the treatment had been less irritating and more supporting in the early stages. These calamities are due to want of prompt and efficient feeding in the early stages. Patients are not hungry, and the attending physicians are not inclined to force nourishment, consequently the patients approach the point of death before any one suspects the danger.

If the stools of a typhoid fever patient be watched, the characteristic exudation of lymph from the inflamed surface of Peyer's patches and other affected glands will be discovered in them; usually if the stools are quite liquid, they will float upon the surface. These masses of lymph are irregular and flattish, varying in size from one-fourth to one inch in diameter. In consistence they resemble masses of recently exuded cherry gum. Early in the disease they are quite clear, but as the inflammation of the glands increases they may become streaked with blood, and in the latter stages of the disease exfoliated patches of the mucous membrane containing the entire glands may be seen. These glands are sometimes studded with clots of blood in their substance. This exudation will oftentimes enable the attending physician to determine the nature of his disease in mild or "walking" cases of typhoid fevers, which for many days may be involved in doubt.

There is one point I wish to touch upon in the physiology, pathology and treatment, upon which authors never, or seldom write, which I think is of great importance in this dreadful disease. I refer to the tendency of the entire circula-

tion in the portal system to become lethargic, both in health and disease, or greatly diminished, so that the digestive system during these periods of rest becomes almost bloodless. The intestines unless distended with food or gases become shrunken and very pale. This in health is a physiological process. The same tendency or function exists in typhoid fever, and then becomes a cause of pathological processes which result in disastrous consequences in the latter stages of the disease. The glands of the intestines are in a congested condition, and during these periods of rest or lethargy the blood in them becomes stasic, and on the return of the circulation to the portal system complete circulation is not re-established in the glands; they, consequently, become gangrenous and slough off. These sphacelated patches can be detected in the stools of the patient if watched for. If in these cases some of the large blood vessels are ulcerated and torn off, hemorrhage takes place and death may result from loss of blood. This is an important feature in typhoid fever, and one that the attending physician must from beginning to end have in view in the treatment adopted.

Biliousness or disordered liver complications in typhoid fever are not so numerous as authors lead us to believe. Undue importance has always been attached to the liver in all diseases, and typhoid fever is not exempt from the myth. Periodicity or engorgement of the liver takes place every time there is increased circulation in the portal system, for there is no other channel through which the blood can be returned to the general circulation and when there is increased vascularity there is increased functional activity. This periodicity of rest and returning engorgement is a healthy function of the organs of the portal system, and should be distinguished from the charges made against the liver, both by the profession and laity, as being "torpid." In the latter case it is assumed that the liver lies inactive, and that its function cannot be restored except by the use of physicians' drugs. This condition I shall dismiss as a "myth."

There is another point in the circulation of the digestive system upon which I wish to make some observations, that we seldom see treated very extensively in any work on physiology or pathology: that is the sectional engorgement of the various abdominal viscera. One portion of these organs may be very abundantly supplied with arterial blood while another section, a short distance away, may be almost bloodless. This condition of the circulation takes place in all normal or pathological states of the digestive system. The introduction of food into the stomach causes increased circulation in the stomach, while the intestines not engaged in the digestive process remain quiescent and almost bloodless. As the food passes along down the intestines they become engorged with blood, and the stomach in turn receives less blood supply as the food passes out of it. Likewise the upper portions of the intestines receive less blood supply as fast as the food passes along down and the process of digestion becomes completed. This same sectional engorgement takes place from any irritation other than digestion existing anywhere along the intestinal or digestive tract. This physiological process may be observed in every autopsy or laparotomy. In a recent case of diaphragmatic hernia the autopsy revealed a portion of the colon, omentum, and caput coli, nearly strangulated in the hernial sac and greatly congested, while the remaining organs were but slightly, or not at all, congested. This sectional and periodical engorgement and bloodlessness of the portal circulation has an important bearing upon the pathology of typhoid fever.

I shall offer only a few suggestions in the treatment of typhoid fever. Beef tea I do not give with the view of receiving any benefit from it; sometimes I allow it in cases where the patient desires it to please his palate, but then I am sure to give the usual amount of nourishment to keep up the strength of the patient. The blood plasma is impoverished by the typhoid poison; the patient grows weaker as a natural consequence; the appetite is wholly or in part lost; the patient is disinclined to take food, and unless the nutrition is made an important part of the treatment in the early stages, the patient may soon lose the chance of recovery.

Proper nutrition is more important than medication. Boiled milk, given cold or warm to suit the patient's taste, with or without some farinaceous gruels, with

sweet cream constitutes the principal food for my patients during the whole course of the disease, other forms of nourishment being added in later stages. This nourishment I give every four hours and no oftener. I do not consult the patient's appetite as to quantity, but give from four to six ounces whether desired or not. This amount given thus frequently is easily digested, and keeps the portal system moderately engorged constantly throughout its entire length, thus avoiding the condition of bloodlessness in which Peyer's patches and other glands become gangrenous and later on sloughing. If digestion becomes feeble, pepsin in some form may be given with benefit. Nausea and vomiting do not deter me from giving nourishment regularly; often nausea and vomiting occur from an accumulation of thick mucous in the pharynx, and care should be taken to have the patient thoroughly awake and throat cleared before taking nourishment. In such a course of diet the stools soon appear soft and of normal color, well stained with bile. Sometimes a diarrhœa appears, which may be checked a little by giving a few drops of laudanum. Three evacuations a day I do not check, nor should I give laxatives if a day passed without any evacuation.

The various germicides and disinfectants I seldom use. I believe physicians rely too much upon such inert, useless drugs. With a stream of nourishment constantly passing along the alimentary canal there is little opportunity for the development and absorption of deleterious germs and poisons into the system. Many of the cases of typhoid fever that I have treated under this method have solid stools pass them, of normal color and well digested; the glandular scabs being found only by washing the stools in warm water, which I do in all cases. Tonics and stimulants I give half-way between the times of giving nourishment.

When the temperature rises high, with a sluggish circulation in the ears and fingers, stimulants are called for in increased doses. If the Peyer scabs are watched for they will be good indicators of the condition of the affected parts. When the stools begin to improve I add to the diet eggs and more vegetable food. The first meat that I allow is pork tenderloin steak, broiled thoroughly all through. It should not be over six months old. I have found it to be a good article of diet in the convalescing stages. It digests easily and is very nourishing. It can be given long before beef-steak or any beef preparations can be borne by the stomach. I have fed it to patients now over twenty years and never have seen anything but good results from its use.

## PEPSIN.

JAMES E. FREE, M. D., Billings, Montana.

### MANUFACTURE ON SMALL SCALE.

Secure the mucosa from the cardiac end of a hog's stomach. Scrape to about half its depth after washing in clear water. Warm the scrapings to 40° Centigrade, with enough 2 per cent. hydrochloric acid solution to completely immerse. In ten days filter and saturate the solution with ammonium sulphate. Pepsin will be deposited in a slimy, sticky mass. Wash the filtered product in a saturated solution of ammonium sulphate. Again dissolve in a 2 per cent. solution of hydrochloric acid.

The next step is to dialyze it in running water to remove ammonium sulphate, and add thymol to prevent putrefaction.

Now add 4 per cent. solution of hydrochloric acid. Precipitate by saturation with ammonium sulphate; add 2 per cent. hydrochloric acid solution. Dialyze in running water. The result is a clear solution, which yields pepsin by concentration in shallow dishes at 40° Centigrade.

Pepsin is of a light brown color, opaque, and occurs in scales, crystals and irregularly shaped masses. Various minor peculiarities are met with, due to processes of elaboration. In home-made preparations the result is not identical in two cases.

Vast quantities of pepsin are turned out annually by the great pork packing establishments of the country, and as they advertise their product attractively and extensively, it has come to be a household

remedy. Physicians may think it a breach of the code to use the pepsin of some of these firms, but provided the drug is fresh, what harm to the patient can result? There are lots of poor, miserable code sinners in the ranks of the profession, and not a few who wear shoulder straps.

The pepsin used in medicine is usually obtained from the stomach of the hog. This is not an ideal source, especially for the Jew. A priori reasoning would lead us to suppose that the dog would furnish a better article. The hog is a vegetarian, whereas the dog and his master are omnivorous, but the hog is better adapted to grow pepsin, so he gets the appointment as politicians say. The ideal source would be the dissecting room, and until observers can point to results obtained by the use of pepsin second-hand our knowledge will not be scientifically exact. Pepsin in the stomach is a living entity. It is a fraction of human vitality. As used in medicine, it is dead Chemistry has supplied us with it as the substitute for the living ferment of digestion, just as it has given us infant's foods, or as dentistry gives us artificial teeth. Where the formation of the enzyme is interfered with it may possibly be good practice to attempt to pull the wool over Nature's eyes by administering the artificial product. If the stomach fails to secrete the proper amount of pepsin, it is proof that it is not in condition to handle the process of digestion.

Dyspepsia, which is caused by an enemy having its grip upon some of the vital organs, such as the vaso-motor system, the heart, or the central nervous system, needs a more radical agent than pepsin.

Before investigating the subject thoroughly, it is often the custom to cram pepsin into a stomach which is sympathizing with its hepatic or nephritic neighbors. Ordinarily ten grains in a capsule has no influence upon digestion. Spallanzani was the Columbus who discovered Nature's secret, hidden in the stomach.

### ANATOMY OF THE PEPTIC GLANDS.

The glands secreting pepsin are situated in a nidus of blood vessels. From the blood, by selection the gland is supplied with protoplasm which enables it to keep itself in repair and also to perform its function in life.

Endosmose and exosmose are illustrated by the processes which go on in these small organs. Continuous waste and continuous replenishing are the necessary results of activity. The gland, being faultlessly nourished, secretes from the protoplasm of the cells, granules which are elaborated into pepsin when a call is made upon the gland by stimulation. The amount of pepsin which the stomach can supply has a limit, and is measured by the granules of pepsinogen in the gland cells. As this is withdrawn to be put to work in the stomach, a fresh supply is stored up. This vital process is accomplished by the expenditure of energy. There is a point beyond which energy cannot be supplied. After that point is reached the symptoms of weariness will begin to show themselves. Continuous stimulation will lead to dyspepsia, but its origin is in the nervous system and demands not pepsin, but rest. Habit will accustom many of the vital processes to a routine not intended by nature.

Where such a routine does not demand an aggregate amount of work in twenty-four hours, equal to ordinary capacity, no harm results.

However, if three years digestive power is expended in two years, the individual grows old too rapidly. He is wearing out life's outfit more rapidly than is necessary. Much of the mortality before three score years and ten, is due to criminal waste of nature's forces. The digging up of such truths is regarded as the business of science. Longevity will hardly increase thus late in the history of the race. Its habits are fixed. It expects to commit these sins, and then demand of medicine that it shall be a shield against consequences. In nearly every case where pepsin is prescribed as an aid-de-camp of digestion, what is actually needed is no digestion at all.

Here is a coffee drinker who is nervous, unsteady and headachy when deprived of his customary stimulant. A dry eczematous rash is constantly present over the sternum. Drinking a pint of hot water three times a day for a week enabled him to break his habit. Appetite improved because digestion was better performed, owing to the fact that the gastric juice was not so largely diluted. Success so far led the patient to experiment further. He had been in the habit of eating three square meals daily. During a whole

summer only two meals per day were taken. Probably as much food was consumed each day as before, but a change for the better became apparent in the patients nutrition. Formerly he had been accustomed to use aids to digestion, such as pepsin and ingluvin. But since the gastric glands have a chance to get the necessary amount of rest, they no longer rebel and medicine is not needed.

THERAPEUTICS.

The ferment requires the presence of hydrochloric acid to do its work. Chemistry has not yet furnished nature a substitute for this particular acid. It required a long chase by science to settle the question of the secretion of hydrochloric acid by the stomach. In fact modern knowledge regarding the stomach is cumulative, extending over a period of one century. Each secret was wrested from nature by the use of instruments of precision.

An isolated stomach when wet is covered with a secretion on its mucous surface, which is glairy and viscid.

Rapid decomposition results in the exposed organ, and changes analogous to digestion are seemingly taking place on the surface from which the gastric juice exudes. The odor is that of pepsin, multiplied several times in offensiveness. Pepsin reminds the healthy nostril of what some call a bilious breath.

When food is ingested the secretory organs are stimulated. Without stimulation there is no secretion. Between meals the average stomach enjoys a period of hibernation. During functional activity, blood congests the tissues of the stomach, the granules of pepsinogen are elaborated into pepsin and freely poured out to unite with the other constituents of the gastric juice. The flow of gastric juice is not uniform any more than is the amount of pepsin. There are degrees of stimulation possible, and the conditions of the various organs of the body exert an influence, both upon amount and chemical composition. Medicines, emotions and mental effort may be supposed to modify the product.

Science now tells us that the changes accomplished in the digestion of food can be imitated by soaking food in superheated water. This shows us that the problem to be solved before creation, so far as a stomach is concerned, was to supply a resource which would do the work of heat, without heat. An evil heart of unbelief would have said before the fact, that such a thing was a wild idea. But there is nothing like demonstration to secure the complacent acceptance of a theory or condition. It is now in order for some bold and skillful operator, under antiseptic precautions, to perform stomato-pancreotomy on a dog, and show to the medical public that genuine happiness is possible by using boiled dinners without pepsin or pancreatic secretion. A seven league stride toward the radical cure for malignant diseases of the stomach will have been taken.

The quantity of pepsin in the stomach during digestion is small. It is necessary for the gastric juice to come into contact with every particle of food stuff, and where by this means the enzyme, in its acid medium, is thoroughly distributed, the splitting up of complex bodies goes on naturally. Ptyalin initiates the digestive process in the mouth when food is masticated. Acid pepsin continues the work by cleaving proteids into two groups: the anti-peptones and hemi-peptones. The former group respond to the action of pepsin and fit themselves for absorption. They are carried into the intestinal canal along with the hemi-group. The pancreatic ferment, trypsin, in an alkaline menstruum, acts on the latter group in a way analogous to pepsin on the former group. Food so treated is then ready for its journey to the tissues.

No actual change in pepsin itself can be proved. It encourages digestion by its presence; it is the mutual friend, the go-between of the stomach and the food. Being so thoroughly mixed with the food, some of it cannot help being assimilated. Once in the blood, in whatever chemical shape, it would naturally find its way to the stomach, where it would be selected as the basis of the elements elaborated by the gastric glands from the protoplasm of their cells to furnish granules of pepsinogen. Pepsin in solution is unstable. Before reaching the part of the alimentary tract where the waste of digestion is held in reservoir, it probably has been chemically annihilated. At least observers do not say that it is to be found there. The intravenous injection of a peptonized salt-solution, or the hypodermic injection of

the same ferment, might be a reasonable method of aiding digestion where secretion is deficient. The discovery of this wonderful agent seemed to open to the therapeutist a broad field which was quickly occupied. Some of the occupants have done nothing but rattle around and make a noise. Very few practitioners have not experimented with pepsin, and the name of the proprietary medicines with pepsin as one of the ingredients, is the Siamese twin of Legion.

In some conditions there is a lack of hydrochloric acid, for instance. There can hardly be a failure in the crop of one of the constituents of gastric juice, and a normal quantity, to say nothing of quality, of another. Digestion cannot be healthfully performed without the acid in the stomach. To pour out pepsin would be a waste of energy. Consequently, when a disproportion exists, nature calls a halt on appetite. Most likely an appeal is then made to therapeutics to force digested food into the intestinal canal. Stuffing is not feeding, and frequently nothing is so scientific as nothing in the shape of starvation. Where constipation exists for want of secretory activity in the gastric glands, hot water makes an excellent prescription. Whether or not acid and pepsin could be added to it with benefit is an open question. The hot water would probably be absorbed before it reaches the part of the alimentary tract where the sluggish contents lie. It is supposed to act by causing secretion from the mucosa of the stomach; by expediting transpiration; by its depurative effect upon the kidneys and liver; by a tonic effect to heart and circulatory system, through the action of caloric on their nervous connections, and by increasing peristaltic motion.

Strong peristaltic motion must be accompanied by freer flow of intestinal liquids. The contents of the channel becomes softer in consistence, and the passage is lubricated, so that the onward movement is favored when muscular action is present. If such activity was induced without secretion, the contraction of the bowel upon its contents would cause irritation, pain and inflammation. The chemical constitution of these contents would not be affected by pepsin.

Digestion, for example in enteric fever, must be carried on in the presence of a toxic ptomaine.

In tuberculosis, the bacillus or the product of its activity, complicates the problem of nutrition. The former condition demands rest; the latter does not call for digestive ferments any louder than for germicides to remove the obstacle to normal function.

All that is claimed for pepsin is that it aids stomach digestion. No virtue goes out of it to any systemic process. Its field is circumscribed to the pouch, called the stomach, which is, first, a receptacle; second, a depot of supply for the material of digestion; third, the place for the performance of so much of the function as can be accomplished in an acid medium. The applicability of an agent which would digest food anywhere in the channel is at least questionable. Only a part of the alimentary tract seems to be adapted to the process.

Nature winds her own clock. If portions of food prove too obstinate for cleavage and hydration, they are forwarded as rejected material. Frequently it is not power to digest articles of food which is demanded, but rather a change of food.

The division of the channel into such well marked sections, must bear some relation to function.

---

### An Eyewash in Cases of Purulent Ophthalmia.

℞

| | |
|---|---|
| Acidi boricis | 3iss |
| Chlor. hydratis | 3ii |
| Acid salicylatis | grs. xx |
| Lot. acid. carbolici (1-100) ad | 3viij |

M.—At frequent intervals the eyes must be washed with the solution, and compresses soaked in it must be kept continually applied to the eyes.

—*Med. Press and Circular.*

---

### For Sweating in Phthisis.

℞

| | |
|---|---|
| Acid salicylic | 2 gram. |
| Aqua purae | 10 " |
| Alcoholis | 6 " |
| Glycerinae purae | 4 " |

M. Sig.—For hypodermic injection at bedtime, 2 cc equal to 20 cubic grams of salicylic acid are injected, repeated every four or five days.

—E. W. B.

---

### Depletory.

℞

| | |
|---|---|
| Iodi pur | gram. .80 |
| Ol. terebinthinae | " 1.30 |
| Ol. ricini | " 2 |
| Alcohol | " 8 |
| Collodii | " 30 |

M. S. Apply daily for three days.

—*New York Medical Record.*

# EUTHANASIA.

CHARLES B. WILLIAMS, A. B., M. D.,* PHILADELPHIA.

"Inveni portum; spes et fortuna valete."

"I have found my Euthanasia, farewell to the battle of life."

Euthanasia means an easy, happy death. The word occurs in Pope's Dunciad, and Lord Byron has a poem so entitled. Seneca, Marcus Aurelius, Sir Thomas More and Lord Bacon were all advocates of euthanasia, and have each written more or less upon the subject. Since then writers have at long and irregular intervals taken up the subject of euthanasia, but very little study has been given to it really; it should, therefore, be a sacred duty of every physician to make this subject a part of his studies, and in the words of Lord Bacon, "it should be as much his duty to smooth the bed of death, and render the departure from this life easy and gentle, as it is to cure diseases and restore health." And where there is no hope, after the physician has exhausted all the resources known to science and has found that it is a case not within his power, "to retain the ties of life," then it should be a grateful and sacred duty, nay, it should be the highest triumph of the physician to minister unto the wants of a dying fellow creature by effecting the Euthanasia.

Death is the separation of the spiritual part of man, the soul, from his body. Yet, in reality, we know not what death is, for "we cannot argue from *the reason of the thing* that death is the destruction of living agents, because we know not at all what death is in itself, but only some of its effects, such as the dissolution of flesh, skin and bones. And these effects do in no wise appear to imply the destruction of a living agent,"† no more, in fact, than the planting of a seed into the earth, for with its apparent dissolution or destruction the plant is born which, in a short space of time, buds and shoots forth its leaves and flowers and becomes a thing of joy to the heart of man.

The same fate awaits all, whether he be emperor or plebian, rich or poor, a prince or a vassal. "When thou takest away their breath they die, and are turned again to their dust." (Ps. civ. 29.) In the charnel house the skeleton or dust of the king will not be distinguished from that of his subject; and Seneca has truly observed that "in this world, men are born of unequal rank, but after death all will be equal."

When the act of dying has already begun, the following signs, first observed and tabulated by the Father of Medicine, Hippocrates, will be noticed: "The nose becomes sharp and pinched; the eyes are hollow and sunk in their orbits; the ears become pale, cold and shrunken, with their lobes inverted; the face is pallid, livid, or black." These signs conjointly have been termed the *facies Hippocratica.*

Contrary to popular belief, the process of dying, or the act of death itself, is *rarely* and exceptionally attended with pain or severe bodily suffering. Physicians who have had ample opportunities of observation from their connection with hospitals or in their private practice, clergymen and intelligent nurses will all bear witness to the truth of the statement.

Sir Benjamin Brodie, whose experience in death from surgical disease was vast, states that from his observation, the mere act of dying is seldom, if ever, a very painful process. Anyone who has had practical experience as an hospital interne will have observed that most all severe forms of injury resulting from railroad accidents, crushes, fatal burns, scalds, etc., while the patient may suffer acute pain early, and for a short time after sustaining the injury, yet as death approaches the end is not one of intense suffering but, on the contrary, is calm and peaceful. On the other hand, take some painful affections of the heart. Here, as in surgical cases, the same rule holds good. This may be exemplified by quoting the words of the celebrated English anatomist, Dr. William Hunter. A few moments before his death, turning to his friend, Dr. Combe, he said: "If I had strength enough to hold a pen, I would write how easy and pleasant a thing it is to die."

Persons who have recovered from apparent death by drowning have all, with one

*Ex-resident physician Pennsylvania Hospital; Dispensary Surgeon Methodist-Episcopal Hospital, Philadelphia.

†Vide Bishop Butler's Analogy of Religion, p. 94.

accord, stated that there was an entire absence of pain or suffering of any kind, while throughout the period of consiousness the mind was keenly active—thought succeeding thought with marvellous rapidity, the whole life of the person being reviewed during the short period of suspended animation. The same facts have also been observed by those who have been partially strangled or hanged. Lord Bacon, in his History of Life and Death, states: "I remember to have heard of a certain gentleman that would needs make trial, in curiosity, what men did feel that were hanged; so he fastened the cord about his neck, raising himself upon a stool, and then letting himself fall, thinking it should be in his power to recover the stool at his pleasure, which he failed in, but was helped by a friend then present. He was asked afterward what he felt; he said he felt no pain, but first he thought he saw before his eyes a great fire, and burning; then he thought he saw all black, and dark; lastly, it turned to a pale blue, or sea-water green; which color is also often seen by them which fall into swoonings."

*Treatment of those dying*: In many cases the consciousness and intelligence remain unimpaired to the last. It is in such cases that kind words and beneficent acts will go far towards assuring a peaceful end to the patient. "To the dying there is no greater solace and cordial than hope—it is the most soothing and cheering of our feelings, and if, when all hope of life and in the present has fled, the dying man can dwell with hope and confidence upon his future, it will be well for him. The retrospect of a well spent life, "Memoria bene actæ vitæ, multorumque benefactorum recordatio," is a cordial of infinitely more efficacy than all the resources of the medical art; but a firm belief in the mercy of God, and in the promises of salvation will do more than anything in aid of an easy, calm and collected death."*

As long as the dying person is able to swallow, wine, cordials, and food, in such a form as will prove most acceptable to the patient, may be given from time to time. Some may ask: Of what use is it to give nourishment and stimulants to a dying person? The mere fact of showing one's concern for him about to depart this life, will be more than appreciated by the patient and will effect his euthanasia. Even our Lord did not disdain or refuse a cooling draught when suffering death. For when his expiatory sufferings on the cross were at the point of being finished, He said: "I thirst;" and the exquisite pain, heat and torture doubtless caused his thirst to be intense. Straightway then ran some of the soldiers, and filling a sponge with vinegar (a mixture of vinegar and water was commonly drunk by the Roman soldiers), they offered it to him upon hyssop. St. John (Chap. xix. 30) tells us that our Lord received and tasted the vinegar and immediately gave up the ghost.

The bed-chamber of the dying should be made as light and cheerful as possible, for the question at issue is the passage of a fellow-being into a life, it is to be hoped, that is spiritual and bright. And frequently the patient himself will exclaim: "Mine eyes fail me, my sight grows dim; give me more light." This dying request should be immediately granted, for it will not only lessen the cares and gladden the heart of the departing one, but it will possess an additional interest from the fact that it may be the last favor that we may be permitted to confer upon one who has been dear to us. It should not be forgotten that the sense of hearing in the dying is often very acute, and that it is one of the last of the faculties to be destroyed. Hence all loud conversation should be avoided, lest it interfere with the patient's peace of mind.

When the mouth and tongue are dry and parched, a few drops of iced-water or a small bit of ice will afford great relief to the patient. The drugs that will be of service in effecting the euthanasia are few indeed. They may be counted upon the fingers of one hand. Of these *opium* stands first, and next in order are *cannabis indica*, *cocaine*, *spirits of chloroform*, and *ether*.

Opium should rarely, if ever, be administered to the dying as an hypnotic, on account of the risk of throwing the patient into a sleep from which he may never awaken. The sole object for its administration should be for relief of pain. By the relief of pain, often an apparently refreshing sleep is induced from which the patient awakens more com-

* Vide Euthanasia, by William Munk, M. D. F. S. A. London, 1887.

posed, and he is thus able to depart more easily when his time comes. In cases of phthisis, or where opium is contraindicated, some preparation of cannabis indica may be administered, preferably the fluid extract or the tincture.

Cocaine in small doses may also be used where there is much tendency toward depression of spirits. Or in place of the alkaloid a mixture of the fluid extracts of cannabis indica and coca may be given.

And lastly, where there is great difficulty in breathing, whether from some disturbance of the heart or lungs, or where there is flatulent distension of the stomach or abdomen, a few drops of spirits of chloroform may be given, or of ether, best administered either under the form of Hoffman's anodyne or of "ether punch," the formula for which is the following:

℞ Aquæ mentæ viridis.....f℥ vss.
Sacchari.....ʒss.
Acid. sulphurici diluti.....mxl.
Spts. ætheris comp.....f℥ij.

Misce et ft. mistura.
Sig.: Pars quarta pro dose.

Many cases will require no medication whatsoever, and in any case, probably, the less medicine that is administered the better.

S. D. Williams, Jr., in an able article on Euthanasia, published in London, 1872, endeavors to establish the reasonableness of the following proposal: "That in all cases of hopeless and painful illness, it should be the recognized duty of the medical attendant, whenever so desired by the patient, to administer chloroform, or such other anæsthetic as may bye-and-bye supercede chloroform—so as to destroy consciousness at once, and put the sufferer to a quick and painless death; all needful precautions being taken to establish, beyond the possibility of doubt or question, that the remedy was applied at the express wish of the patient."

The above statement would make an excellent text for a long essay or a spirited debate in a medical society. At the time of its publication it created no end of discussion. In answer to it:—It were better, by far, that chloroform had never been discovered, rather than it should ever be put to so base and awful a use as to wilfully take away the life of a fellow creature in order to effect his Euthanasia.

# COMMUNICATIONS.

## A CASE OF EXTREME LOW TEMPERATURE.

GEORGE R. DEAN, M. D., Spartansburg, S. C.

Mrs. S., sent for me on October 11, 1893. I found her dressed but reclining on the sofa. She had been complaining of pain in the calf of the left leg for several days, and upon examining it I found a plexus of enlarged veins, with knots outlying in several directions. The leg was not swollen except at the point where the trouble had occurred, a place as large as say the half of one's hand. There was pain and tenderness on pressure and some constitutional disturbance—not much, however; tongue coated; pulse a little fast and accentuated somewhat in its beat; bowels constipated. Gave small dose of calomel and soda every two hours for four doses, followed by salts. I bandaged the leg instructing her to remain perfectly quiet, to occupy a horizontal position as much as possible, and to be up only when compelled to answer the calls of nature. This occurred on Tuesday 11. I did not hear from her again until that day one week, October 18, when I was called again. I found her in bed this time, with the leg swollen to the foot, and œdematous even above the knee. Temperature 101° F.; pulse about 90; skin looked sallow and thick. She seemed rather dull, just as would be expected from the trouble in the leg. This had extended on every side, and was very tender to the touch. Prescribed witch hazel, quinine with laxatives, and pressure by bandages.

I saw her every day for the next eight weeks, and during that time a succession of symptoms developed that were peculiar and some of them surprising to me. She early showed symptoms of disturbance of the brain and became to a certain extent

unmanageable. For instance, if medicine did no taste or smell agreeable to her she would not take it at all, and thus she would often go without medicine for a whole day, or until I could see her and change her prescription to a more agreeable dose. During the week following after my second visit her temperature rose gradually from 101° to 103.5° F., and the swelling in the left leg gradually increased until it had reached the hip. A condition of typhoid now developed and for three weeks the trouble in the leg was at a stand-still—headache, diarrhœa, tympany and the dull, sodden countenance, with the temperature ranging from 101.5° in in the morning to about 103.5° in the afternoon; pulse full and strong; tongue dry, furred and red. Her mind at the end of four weeks from the beginning of last trouble, or about November 15, had become almost *nil.* She was unconscious of all around her save when aroused, and then no reliance could be placed upon her report of herself. Often she would tell long stories about herself that were totally at variance with facts.

At this time, as her fever began to decline, I suddenly discovered one day that her temperature had fallen to 97.5°. This I could not account for. The next day I found trouble in the bladder. It was tender, painful, and soon became paralyzed, and, my attention being called to the fact that she had passed no water for some time, save a little dribbling, I found it full, and emptied it. She had no sensation of distention, and when asked about it, said she had no desire to pass water. This kept up for five or six days, when she could again void the urine herself. Peritonitis followed and then I began to think the end was near, as did also Dr. Heinitsh, who visited her with me. We could see no cause for the peritonitis save the sepsis from the original phlebitis. As this, under careful and supporting treatment, gradually subsided, her temperature began falling during several hours a day to 96° After this trouble had about subsided, her heart became involved. She complained of great pain in this region, and a distinct systolic murmur could be heard at the apex. Temperature fell during this time to 95° for a few hours each day. As the heart trouble improved, pneumonia of right lobe set in, and with great difficulty she kept up the respirations. Often they would amount to 60 to the minute, and one day, by actual count, they reached 72 per minute. I kept close to my patient now, as each day seemed to usher in some new trouble.

The pneumonia lasted six days, and she weakened perceptibly, but I had her take all the nourishment possible. Strychnine, digitalis and ammonia constituted my principal treatment, with counter-irritation and fomentations over the lung. The urine now showed much albumen, as would be expected, and in a few days œdema of the face, eyes and hands set in. Before this, however, both legs again became involved with phlebitic knots and corrugated varicose veins. I kept both bandaged from now on until convalescence was established. As the cheeks became œdematous, the temperature reached 93° for several hours each day. I thought surely the end could not be far away. I tested the temperature with three different thermometers, and they did not vary one-fourth of a degree. I could not take the temperature in mouth or vagina, for, notwithstanding my patient was in a partial coma, she would know when touched, a d fight any and every one who did anything to her, save such as she herself wanted. Often for a whole day I could not prevail on her to take food and medicine or show me her tongue, and it was with the greatest difficulty that her wants could be made known to us, her speech was so indistinct.

Her right side now showed signs of paralysis. She ceased to move the right leg or arm, and would not change her position for days at a time. After some days the anasarca began leaving slowly, and my hopes were again elevated, as much as at the various stages they had been cast down. She began to eat and sleep better, and noticed those in the room and seemed to be better generally. On one of my morning visits a few days after these signs of improvement, I was told by the nurse that the temperature was down again—I examined and found it at 92½° I knew there was some mischief somewhere brewing, so I examined every organ in the body to see where the stroke would be, but I could find nothing save slight tenderness of the bladder. The next day temperature 92°, coma almost complete, discharges involuntary, and nothing seemed to recall my patient to things around her. I detected a fearful odor in the room,

different from anything I had experienced before, and was told it was from the bowel. I could scarcely believe it and examined the bladder per vaginam and bi-manually. Upon pressure over that organ, and counter-pressure in vagina, with frequent and loud expulsive sounds of gas escaped from the bladder, and such an odor! That at once accounted for the disagreeable scent in the room. I at once began washing out the bladder with boracic acid, twice a day. For several days no improvement was detected. Enormous quantities of flatus and mucous membrane came off each day, but soon began to lessen, and in ten days all the trouble seemed to pass away.

The stomach, which always sympathized in her troubles, now returned to its wonted standard, and the appetite and digestion were all that could be asked. From this time on she steadily improved. Only one serious relapse—after eating a quantity of hash, of which she seemed especially fond, she had an attack of cholera morbus which soon passed off.

Her temperature for several hours at a time would fall to its lowest ebb and in the last attack, fell to 92° five days successively, but at no certain period. It would be down to-day at 10—to-morrow at 5 A. M., next day at 5 P. M., etc.

On Feb. 11th, she took her first airing out-of-doors—and seems now to be regaining her mental and physical strength. The range of temperature here was extraordinary. The difference in the highest and lowest points being 11½°.

N. B.—One year after the above notes were taken down, this patient is well and attending to her domestic duties, apparently in better health than for several years previous to her illness.

## TRAUMATIC MENINGITIS.

FRANK E. COUDERT, M. D.,* WALLINGFORD, CONN.

On March 8th, 1894, I was hurriedly summoned to see D. C., an infant girl, aged fifteen months.

The following is the history I obtained from one of the bystanders:

Mr. and Mrs, C—were out at the time of the accident, the child being left in charge of a competent (?) nurse. The nurse having work to do in the attic, brought the child along with her for safe-keeping. Suddenly D. C., who was just learning to walk, broke away from the girl and threw herself against the window, which was opened, and only four inches from the floor. She went head-first out, and landed upon her head on the ground beneath, a distance of thirty feet.

When I saw her, thirty-five minutes after the accident, her face was greatly cyanosed, respiration rapid and irregular, pulse small and feeble. I gave her twenty drops of brandy by the mouth. In a few minutes an improvement was seen. The face became normal in appearance and the pulse regular.

On examination the only injury I could find was a slight brush-burn on the right side of the head, extending from the upper border of the parietal to the middle of the temporal bone. I gave strict orders to keep cold applications upon the head during the night. Five grains of bromide of potash were given every four hours throughout the night. She passed a comfortable night and a good forenoon. On the afternoon of the 9th, a marked change for the worse occurred, being in a comatose condition with a marked strabismus; temperature 103°, pulse 140.

On the 10th, at 9 A. M., Dr. W. S. Russell was called in consultation. We agreed that we had a case of traumatic meningitis to deal with, and the following plan of treatment was settled upon.

Constant application of cold to the head (the cold coil being used). Five grains of bromide potash every four hours; one-quarter of a drop of tincture of cantharides with two grains of iodid of potash every six hours. A cantharideal blister behind both ears. Brandy P. R. N.

Early in the morning of the 11th, our patient was in a state of collapse. Hot water and milk were used per rectum, while small doses of compound spirits of

* Member of the New York County Medical Association and the Connecticut State Medical Society; Town Health Officer.

matics who often suffer from urticaria, tried it in cases of uncomplicated chronic urticaria where the usual means had failed. He has treated with success four rebellious cases; a fifth was acute and of five days duration. None of these cases were syphilitic. All he cured rapidly by the admistration of a solution of potassic iodide in the proportion of 2.5:100.0; of this three soupspoonsful, three times a day. In a case which had persisted for four months, the atrocious itching disappeared on the second day of treatment; a complete cure was obtained after taking ten grams, (ʒijss), of the drug. In two other cases of longer duration, two and a half and six years respectively, the effect was similar and a definite cure followed after ingestion of respectively twenty-five and seventy-five grams of the iodide. Finally, in two others, one an acute and the other a recurrent case of three years duration, the drug increased the pruritus at first, though this was but transitory and a cure was obtained with five grams. These observations though not numerous, indicate that the iodide of potash is worthy of being classed amongst the remedies for urticaria. He also referred to a case of chronic urticaria successfully treated by Wilson with this same drug.

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RESORCINE IN ULCER OF THE STOMACH.

Dr. Pope (*Memorabilien*, No. 2, 1894), recommends a two per cent. solution of resorcine as the most efficacious remedy in the treatment of round ulcer of the stomach. A tablespoonful before each meal. Also rest and appropriate diet.

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FEVER OF TUBERCULOSIS IN CHILDREN.

Dr. B. Rachford (*La Semaine Madicale*, No. 31, 1894), in the fever of tuberculosis in children, advises the following salve:

℞ Guaiacol,
Lauoline.....āā 4 | o (ʒi).
Lard..... 30 | o (ʒj).

Rub a piece of the size of a small nut, every evening into the thorax.

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TREATMENT OF THE CARDIAC WEAKNESS OF ARTERIO-SCLEROSIS.

Dr. A. Smakowski (*Memorabilien*, No. 2, 1894), has employed the usual treatment of the final period of arterio-sclerosis which is accompanied by cardiac weakness, as valerian, ether, digitalis, strophanthus, caffeine, etc., and in two cases has observed embolism of the cerebrum—arteria fossæ Sylvii—to follow. He thinks it more rational to administer in such cases only narcotics. These relieve the heart in that they act as sedatives to the nervous centres. Choral hydrate and small doses of morphine were used by him. During the attack he administers:

℞ Chloral Hydrate
Bromide Sodium.....aa 4 | o (ʒj).
Codeine..... o | 1 (grs. jss.)
Distilled water.
Syrup Orange Peel....aa 45 | o (ʒj ʒiij gtts. xv.)

A tablespoonful every two hours until the patient becomes quiet. Not more than three tablespoonsful in succession.

Besides ice is applied to the region of the heart, subcutaneous injections of morphine are given ($\frac{1}{10}$ gm.), absolute rest and a light diet. After the patient has been quieted he then administers heart stimulants.

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EAU DE COLOGNE IN COLDS IN THE HEAD.

Dr. Roux (*Norsk Magazin for Lægevidenskaben*, No. 5, 1894) recommends Eau de Cologne in the treatment of acute rhinitis. A little is poured onto a handkerchief and inhaled forcibly for several minutes through the nostrils. This is repeated five to six times a day. In eleven cases he has observed good results, even in cases where there was a slight rise of temperature. He thinks that thus he has been able to abort a cold for several of his patients, who when they would take cold in the nose it would be followed by a tracheo-bronchitis. The remedy was of the following composition:

℞ Ethereal Oil Bergamot,..... 10. | o (ʒijss.)
" " Sweet Orange,.. 10. | o (ʒijss.)
" " Lemon,..... 2. | o (gtts. xxx.)
" " Rosemary,..... 2. | o (" xxx.)
" " Bitter Orange,.. 2. | o (" xxx.)
Alchol, 900..... 100. | o (ʒiij ʒj.)

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PILOCARPINE IN PANCREATIC COLIC.

Prof. Eichorst (*La Semaine Médicale*, No. 31, 1894,) in a case of pancreatic colic; pain in the right hypochondrium, fever, ptyalism and intermittent glycosuria, caused the pain and other symptoms to disappear by hypodermic injection of, at first, one c. cm. of a 0.5 per cent. solution and later, that quantity every two days. The drug favors expulsion of the pancreatic calculi by increasing the secretion of pancreatic juice.

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SATURDAY, JUNE 30, 1894.

## EDITORIAL.

### STYLE IN MEDICAL WRITING.

The late Dr. John Brown, whose *Horæ Subsecivæ* a doctor will not fail to read, and having read once will read again, said that our medical writers now-a-days, with a few signal exceptions, write ill; that they are slovenly, diffuse, often obscure and curiously involved. Among the reasons given by Dr. Brown for this condition are, the enormous amount of merely professional knowledge a man is expected to master before he writes on any subject, and the absorbing nature of the new methods.

One of the causes of bad writing in modern compared with ancient times, which applies of course not exclusively to medical literature, is punctuation. It can be readily understood that those writing before the art of punctuating obtained, were compelled to be very accurate in syntax, else the force, if not the meaning of the utterance would be lost. It was also impossible for them to make the long sentences we find to-day, especially in many German writers. Punctuation came with typography, and as a consequence we may meet now and again a sentence crowded with clauses and qualifications, sometimes indeed not free from episodes, so that the chief thought, or thoughts would be lost were not a clue given by punctuating marks. The witty New York lawyer and statesman, who is famous for his prolix passages, once answered a critic by saying, "Criminals always object to long sentences." But in composition such sentences weary the reader and often obscure the thought. The error referred to may result from the employment of unnecessary words. How often, for example, a noun strong enough in itself is loaded with two or three adjectives; the writer is straining after effect, as it is called, and in the effort loses it. Further, unrelated things are dragged into a sentence, making an incongruous mass of words, and length, not beauty or strength, results. Clear thinking will lead to clear and condensed expression. Life is short and

time is fleeting, especially with the doctor, and he greatly prefers extract of beef, or a good steak or roast, to being compelled to devour horns and hoofs, tail and tallow, skin and bones in getting his needed nutriment.

The medical writer should take for granted that his readers know something —it is not necessary for him to tell them how to spell baker—and hence let him omit all unnecessary facts and details in his communication: thus doing he will have more readers, and they will know more.

We have alluded to straining for effect, in one of its forms, as an error in writing. There are other ways in which this is intentionally done. For example, there are writers whose style is purely artificial, who affect tricks of words, peculiarities of expression and extravagancies of statement, as if they were shouting, "Listen to me!" Whatever is well-said carries in itself the call for attention; hysterical rhetoric, which has no more force than foam upon the waves, is not needed; nor is mental tympany, which goes off with a great noise and nothing else. Such writers are in no respect good models of style.

As little worthy of imitation is the egotism manifested by some writers. Money-making is the chief purpose of their lives, and their goods have a trade mark. I is so often repeated in their writings, the egotistic nature is so plainly and painfully apparent, that the first person singular cases to be singular, is indeed multi-plural, and one finds I as frequent on a page as eyes of another sort are numerous in the tail of Juno's bird. To the unwary it seems as if these egotists possessed all wisdom, knowledge and skill, they only understanding what to do, and how to do, and to them let all patients be consigned. That this sort of work pays, as the saying is, seems evident from the large number engaged in it.

Nevertheless, the best professional work, the most useful and abiding, must be that stimulated by unselfish motives and a high ideal. The honest and conscientious physician will especially ponder the wise words of Lord Bacon, so applicable to medicine, that "knowledge is not a shop for profit and sale, but a rich storehouse for the glory of the Creator, and the good of man's estate."

So many topics crowd upon us, and space is so limited, that we are compelled to restrict the conclusion of this article to some remarks upon the means by which a doctor may acquire a good style.

As our manners are largely formed by the society in which we move, so our writing depends chiefly upon the authors we read. Among medical writers none is superior to Watson. It is a pity that his work on medicine is no longer a text-book, for its study would be most helpful to young doctors in acquiring a style at once clear, strong and graceful. It would be well for the physician, though having more recent volumes upon practice in his library, still to keep that of Sir Thomas Watson, and to read in it from time to time. Works upon diseases of women and upon diseases of children are numerous, but we know none equal so far as literary merits are concerned, to those of Dr. Charles West. We have sometimes wondered whether the multiplicity of illustrations, plates and wood cuts, furnished for professional books now-a-days has not caused carelessness in writing; for why describe accurately and clearly, why make a word-picture, when an illustration can be used?

While selecting Watson and West as models of medical writers, other names could be mentioned of men whose pages delight while they instruct, but we must pass to general literature, making brief reference to the part which the study of certain authors or books contributes to the obtaining of a good style.

The Bible should be placed first among books of study for this purpose. Cole-

ridge said, intense study of the Bible will keep any writer from being vulgar, in point of style. We add that such study will help give clearness, simplicity, beauty and strength of style. And here permit an apparent digression. An authority in architecture once said, if you are in doubt as to the color your house in the country should be painted, pull up a native shrub or small tree, and notice the color of the soil that adheres to the roots. That should be the color of the house. So, too, if one observes the language used by plain people, men and women of average education, when a great trial or sorrow comes to them—some deeply rooted object of love torn from their hearts—he will often be struck with the simple strength of their words; he will have a higher appreciation of the English tongue, and learn an important lesson in its use. Now these plain people to whom we refer, most probably are more familiar with the Bible than with any other book, and chiefly got from it their mode of speech.

All are familiar with Johnson's remark: "Whoever wishes to acquire an English style, familiar but not coarse, and elegant but not ostentatious, must give his days and nights to Addison." We would like to add several other names to that of Addison, as authors to be read in the study of style. We urge a place for Swift, who wrote with such perfect command of language, and so accurate a discrimination in the choice of words; we wish that doctors would read Fielding, and it would be unfair to one of their own guild to omit Smollett. Southey will be read, at least that quaint volume so rich in various learning, "The Doctor." Of course they read Shakespeare, and an occasional page from Jeremy Taylor will enrich their minds with noble sentiment, classic learning and poetic imagery. It would be professional disloyalty not to read Sir Thomas Browne, more especially "Urn-Burial," "Christian Morals, and last, though not least, *Religio Medici*.

Let us say a word for Coleridge. More than thirty years ago an American physician was the guest of an eminent member of the Dublin profession, and one evening the conversation happened to be upon this great philosopher and poet, when the Dublin doctor gratefully spoke, "Coleridge taught me how to think." The "Aids to Reflection" had been the special means of instruction to this distinguished doctor and author, long since dead. And therefore we urge at least this volume upon doctors who desire to know not only how to think, but also how to write.

The list of authors is by no means complete; we could justly add the names of Pascal, Macaulay, Emerson, Holmes and Ruskin, and advise occasional reading of DeQuincey to note the careful selection of words and their admirable arrangement so that a sentence is built up like a Grecian temple, perfect in beauty and strength. Among poets in the doctor's library, we ask a place for Tennyson, Mrs. Browning and Longfellow.

But for the present we dismiss the subject, trusting that some little has been said which may be helpful to the writers of the profession, who may be sincerely desirous of acquiring a style which shall be attractive and effective in communicating their thoughts.

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### Sciatica.

℞ Tinct. aconite rad..... 4 gram.
Tinct. colchici sem..... 4 "
Tinct. belladonnae..... 4 "
Tinct. cimicifugae..... 4 "
M. Sig.—Twelve drops every four to eight hours.

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### Laryngitis.

Tinct. aconite rad..... 15 gram
Sig.—One drop every hour in water. Best results when following a dose of castor oil.

—*Sargins*

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### Antiseptic Solution.

℞ Acid thymic..... 1 gram
Alcohol, at 90 per cent..... 4 "
Aq. destil..... 995 "

—*Medical Record.*

# SOCIETY REPORTS.

## ORTHOPÆDIC SECTION, COLLEGE OF PHYSICIANS.

*April 20th, 1894.*

### DR. T. G. MORTEN PRESENTED, THROUGH DR. WOODRIDGE, CASES OF DOUBLE EQUINO VARUS WITH REMOVAL OF ASTRAGALI.

Case I. Mary J. McK., one year, ten months old; living at Bryan Mawr, Pa., congenital, uncomplicated, talipes equino-varus. Operation of division of tendo Achilles performed February 21st, 1894, Posterior right-angle tin splint for a week, followed by ordinary brace, side steel support. April 20th, apparatus discarded every other day and plain shoe allowed. Foot in good position. Result perfect.

Case II. Benj. Jordan, two and a half years old. Living in Philadelphia. Double uncomplicated, congenital talipes equino-varus. April 5th, 1894, operation of division of tendo Achilles and tendon of anterior tibial by open incision. Rectangular, posterior splints, dressed a week after operation. Also division of flexors of all toes,

Case III. Orm Gantt, 5 years old, living at Island Heights, N. J. Admitted into the Orthopædic Hospital January 17th, 1894, with the statement that he had been deformed ever since birth; having double Talipes equino-varus so that in walking his feet were turned in, so that he walked upon the dorsum of each foot. When 8 months old he had been operated upon at the University Hospital. He then wore braces until 3 years of age. He did not remain in the Hospital after operation and the after treatment was probably neglected.

After admission, his feet were poulticed for three nights, in order to soften the callus on the dorsum of each foot. The operation was performed on the 25th of January. Dr. Morton severed the flexor tendons of all the toes, the anterior tibials and the tendo Achilles of each foot. He also made an incision three inches in length on the outer aspect and dorsum of the feet through the callus, and simultaneously removed the astragalus and part of the cuboid bone of each foot. The rectangular, posterior, tin-splints were used as in the other cases. There was no rise in temperature after operation, Dressed for the first time on the 8th of February. Wound well healed. He continued to wear the rectangular tin splint until March 3d, when braces were applied which he is still wearing. Feet are now straight and in good position. Wounds entirely healed.

#### DISCUSSION

DR. G. G. DAVIS: There are two things in regard to this case which occurs to me. First, as a rule I do not believe in open incision. The only advantage is when one cuts down upon bundles of contracted tissue; but in division of a healthy tendon, in an equally healthy patient, I do not think it necessary. In a case of torticollis where we have dangerous structures in the neighborhood, and where there are contracted tissues and a tendon that does not slide in a synovial sheath, then I would use an open incision,

Some time ago I showed at the County Medical Society several cases of wedge-shaped resection. As for myself, I have never seen a case at the age of five years in which I could operate upon the bones. In one case which I showed at the College of Physicians, aged six or seven years, the child walked upon the dorsum of the feet, toes pointed toward each other and the sole vertical, yet it was cured without operating on the bones. The bones in cases of this age are soft. I showed an astragalus, removed by another surgeon, which was so soft that I could push a pin through it, with my finger, in all directions.

I do not believe that excision of the astragalus alone, in cases which demand operation on the bones, will straighten the foot; therefore when bone is required to be removed I believe the deformity can only be rectified by severe measures. In removing the astragalus, a portion only of the obstruction is removed and the external arch is left intact, and the deformity which remains is so great that it demands further procedures on the outer side of the foot, such as a removal of a portion of the cuboid or anterior portion of the calcaneum. A foot that can be straightened by removal of the astragalus alone is usually one which can be cured without operation on the bones.

DR. WOODBRIDGE: I thank the Section for the courtesy of allowing me to present these cases, and as I have another engagement I will not enter the discussion. I have only one word to say, I understand that Dr. Morton never removes an astragalus when it is in place; it is only when it is deformed.

DR. DEFOREST WILLARD: In tenotomy of the posterior tibial tendon, especially in fat infants, open incision is desirable. No surgeon, however, works in the dark in sub-

cutaneous section of the tendo Achillis and this method is just as exact as the open one since an amount of material will be thrown out, proportionate to the separation of the cut end.

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ABSTRACT OF "REMARKS ON THE USE OF A BRACE IN LATERAL CURVATURE FROM EMPYEMA."

DR. G. G. DAVIS: At a recent meeting of the Section, when I exhibited a patient about 7 years of age wearing a brace for the correction of lateral curvature resulting from empyema, the views expressed by some present were so at variance with my own, as to induce me to more carefully examine into the subject and ascertain whether the brace, as ordered, was likely to be of service and desirable.

A discharging sinus, existing in the left chest wall of the child for more than a year, was only recently cured. Examination posteriorly showed the whole trunk, from the pelvis upward, inclined toward the right side with a slight lateral curvature in the upper dorsal region, the convexity being to the right. The right shoulder was higher than the left, and the right scapula formed quite a prominent projection. Laterally, there was a slight forward inclination of the right shoulder which increased the prominence of the right scapula. On the left side there existed the scar and depressed cicatrix where the ribs were excised; and contraction of the altered intra-thoracic tissue had taken place, accompanied by sinking in of the chest wall and lowering of the left shoulder.

As the general object in using braces and apparatus is to correct certain alterations in the form of the body, let me examine the mechanical problems suggested and the means taken to solve them. First, then, as the deformity was confined to the upper portion of the body, therefore the means of correction were applied to that part. Again as the lower portion of the body was normal, it furnished a fixed point of support for the application of the correcting force, consequently a steel band was made to encircle the pelvis between the great trochanters and the crests of the ilia, and fastened in front by a strap and buckle. To increase the hold of the band, a wide linen belt was attached to it, and reached from the trochanters to the ribs. It was secured by two buckles in front. Four steel uprights were attached to the steel band, one under each axilla, and one on each side of the median line posteriorly. A transverse steel bar was fastened to the upper ends of the uprights, and curved so as to be high in the middle of the back and low under each axilla, forming a crutch.

Placing the child on his back and firmly strapping on the brace, corrected the lateral deviation of the trunk. Next, to correct the elevation and forward inclination of the right shoulder and accompanying projection of the scapula, a strap was passed from the anterior end of the right crutch over the shoulder and attached behind. This drew back the shoulder and corrected the tendency to stooping. Finally, to make lateral pressure over the projecting lump in the right upper thoracic region, a wide elastic band was fastened by straps to the right axillary upright on the left side of the spine. This made excellent pressure and completed the requirements of the brace. An apron had been attached by the mechanician, but as there was no necessity for it, I removed it.

In another case, instead of fastening the elastic band to the axillary upright, I shall attach it to one running between the anterior extremity of the crutch to the pelvic band, and so obtain a more directly laternal force. This brace offers no hindrance to the free expansion of the contracted chest, and in no way prevents the patient from running, playing, or indulging in exercises and gymnastics, such as swinging from rings, horizontal bars, etc. Morning and evening, after removing the brace, he exercised by bending forward and backward and from side to side. The most important principle involved in the use of the brace in this class of cases is the means to be adopted to secure the expansion of the affected lung and chest wall. Is it better to allow a patient, with a recently healed wound and a marked deformity, to go without any attempt at correction on our part, or should we, by a portable brace, endeavor to maintain a gentle and persistent pressure on the distorted parts which will cause the contractions to gradually yield, yet not interfere with the expansion of the affected lung; while at the same time, the child is prevented from assuming any posture favoring persistence of the deformity? I have preferred the latter with such exercises as he can take, believing it much more efficient than the spasmodic stretchings of intermittent excercises, interspersed with periods in which the body will be inclined to the affected side and every oportunity given for contraction to take place. After the deformity has been partially reduced and the tendency to assume objectionable positions somewhat overcome, the brace may be discarded and therapeutical gymnastics alone employed.

SCOLIOSIS.

DR. J. HENDRIE LLOYD: I have no set paper. I simply wish to make a few remarks and to show a few photographs. I think the nervous origin of the disease is not sufficiently recognized by surgeons. It is important that it should be. It is seen especially as a complication of nervous diseases, as syringomelia. In a recent monograph, Bruhe says

that in fifty per cent of cases of syringomelia, scoliosis occurs. Some of these cases are also associated with marked kyphosis.

One case of syringomelia has come under my notice in which the deformity was similar to that shown by the skeleton here exhibited. One point in connection with scoliosis in syringomelia, is shown by this photograph. In some cases when the patient is in the recumbent position, the deformity is obliterated. This case, seen in the photograph, simulates torticollis, because the scoliosis is high in the cervical region.

The second case with which scoliosis is associated is Freidrich's ataxia. It is a disease of the spinal cord, seen in childhood, and we are apt, again, too frequently to overlook it. It is allied to another form of disease which we may call disatrophy. I have under my care, at the Home for Crippled Children, a girl, aged eleven years, in whom there is marked muscular disatrophy; there is secondary affection of the joint at the knee and ankle, and there is scoliosis. While not a typical case of Freidrich's ataxia, it is closely allied to it. There is probably some change in the tissue of the spinal cord. The photograph of the case shows the deformity at the knee and ankle, but even while lying in bed, the twisting of the knee can be seen.

The last form of nervous disease which is confounded with scoliosis is shown by this photograph; the case had been under the care of a surgeon. When I went on duty at the Methodist Hospital, I found this women with the affection of her knees; the surgeon had tapped them. As the case did not seem to progress, it was turned over to the Medical Wards. I was struck by the peculiar deformity of the hand which neurologists call "main en-griffe." There was complete atrophy of the shoulder girdle. There was marked scoliosis. In short, the woman had muscular atrophy affecting the shoulders, arms and hands, with spastic symptoms in the legs, and with scoliosis and arthropathies. There were no sensory symptoms. The case was doubtless allied to syringomelia. It is interesting to note that it had been regarded and treated as a surgical case.

A number of hypotheses could be advanced to account for scoliosis. One observer says that all cases of scoliosis are allied to arthropathies; for instance, it is identical in the joints of the spine with arthropathies in the knee. Roth says it is due to muscular atrophy. Another hypothesis is that they are distinct trophic lesions, something like progressive atrophy.

When a case is of nervous origin, the scoliosis, to a certain extent, is an evidence of Nature's effort to put the diseased spine in a better position. I never saw a case which would tolerate an apparatus. Most of the cases suffer great pain if attempt is made to straighten the spine. I recently admitted to my ward in the Philadelphia Hospital a young woman affected very similar to some cases already mentioned; there is marked progressive muscular atrophy. She could not bear a brace of any sort. My remarks are entirely from the standpoint of a neurologist; I say nothing about the condition associated with empyema.

DISCUSSION.

DR. C. K. MILLS: I have had two cases of syringomyelia in which syinal curvature was was present. The cases of degenerative disease, and syringomelia in adults, are not the ones most likely to show deformities, but these occur most frequently in Freidrich's ataxa and the affection closely to it, pathologically, which show themselves early in life; but even in adults lateral curvatures do take place. I believe with Dr. Lloyd that little can be done with apparatus. In many other degenerative embryonal diseases, which are due to arrested development, my experience teaches me that little can be done either by operation or by apparatus, especially for the porencephalous cases. In spastic cases, either unliaterial or bilateral, some advantage can be gained as to pssition, but nothing more.

DR. G. G. DAVIS: The orthopædist ought not to be too strictly called to account, because I think they would not put on an apparatus for an advanced case of pure nervous disease, except as a palliative measure. Much can be done by apparatus and it depends upon the nature of the case greatly. If an apparatus will give any additional comfort to the patient, it is oftentimes advisable to order it. In regard to the cases referred to by Dr. Lloyd: in Freidrich's ataxia, a light brace might aid in supporting the body, and in Charcot's joints, a mechanical appliance does for a time support, and gives at least some slight relief, which is more than can be promised by medical treatment. I believe in the necessity for recognition of the points of a case, but I do not think that the application of apparatus is always useless.

Dr. J. Hendrie Lloyd: I should like to ask Dr. Davis if he would put an apparatus upon a Charcot joint. It is a matter of interest to me as a surgical question, and I should like to hear it discussed. I think, in these cases, the surgeon sometimes does not recognize the exact nature of the difficulty. I know of one case, however, in which a surgeon operated on a spinal arthropathy, the exact nature of which he did not recognize, and in which marked benefit resulted from the operation.

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TORTICOLLIS.

DR. C. K. MILLS: The patient shown here to-night came to the Polyclinic Hospital

last week. I have not full notes of the case, but the history is as follows: The man is thirty years of age, a painter by trade. The difficulty started slowly; at first he experienced trouble in holding his head still. When reading a paper, in spite of everything he could do, his head would slowly turn to the left. He has no pain, but this has persisted and is slowly growing worse. The case is one of a class somewhat common, and, as we all know, most difficult to help. I have had considerable experience in what is termed spastic torticollis, both of the tonic and cloric varieties; they are most obstinate and may resist treatment for years or forever. One case in particular occurs to me, a patient whom I showed at my clinic, and an account of which was reported in the University Medical Magazine. She has three surgical operations on the spinal accessory, and she had been burnt with a hot iron many times, but no help was obtained. I have brought this man here to-night to obtain suggestions as to treatment. I have seen cases get well, but it is an affection difficult to cure because we do not recognize the underlying anatomical conditions.

DR. J. HENDRIE LLOYD: It is my opinion that torticollis involves a problem which we do not all understand. Prof. Ferrier and Mr. Horsley advanced the theory of a localizing torticollis centre; at that time we were ready to localize anything and everything. But certainly we do not understand the condition.

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A paper on "The Treatment of Scoliosis by Free Movements and Apparatus," was next read by Dr. Randolph Fairies, in which he held that as the deformity is due to the concerted action of certain muscles or groups of muscles, therefore these should be kept inactive until their antagonists have been developed by means of exercises and gymnastic apparatus, sufficiently, to counteract the power exerted by the former ones. Also that the deformity, being compound, should be corrected in the same order as it occurred, that is, the rotation is first corrected, then the lateral curvature.

DR. WM. J. TAYLOR: I regret that I was not present at the reading of Dr. Faries' paper, as I am particularly interested in the treatment of spinal curvature by gymnastic exercises. I am glad to say, however, that such portion of the paper as I had the pleasure of listening to meets my views entirely. But, for the reason already given, I am prevented from discussing the paper intelligently.

DR. C. K. MILLS: I quite agree with Dr. Faries as to his method of treating spinal curvatures, but the difficulties in the way are great. Little can be done in this direction until the colleges set the example, and until, in connection with every hospital, a room is set apart for this purpose and is put in charge of a competent assistant, who can carry on the work year after year.

It is essential that we should impress upon ourselves and our patients that this treatment should be carried out systematically for two or three years if necessary. Great steps in advance will be made when the teaching institutions lead the way. One of the tendencies of modern medicine is in this direction, and steps should be taken immediately to further and further advance the treatment.

DR. G. G. DAVIS: Lateral curvature is a subject much considered by the orthopædic surgeon, and for it, much good can be done by gymnastics. There are two classes of such cases. In the mild ones, where the muscles are at fault, and the spine itself comparatively healthy, therapeutic gymnastics are of no service, But there is another class in which the pathological process is more profound and in which the bone and ligamentous tissues are likewise affected, and as the spine is the organ for keeping the body erect, the simple weight of the body which is supported by the spine will tend to cause curvature of it, and the tendency to distortion is increased by the efforts of the muscles on both sides of the spine. I believe that where this condition exists, the spinal column will give way and deformity will occur rapidly; in these cases exercise is of little or no service. I believe that there are cases of lateral curvature which might be termed malignant. The deformity goes on increasing, and in spite of most careful treatment, the patient rapidly grows worse.

DR. RANDOLPH FARIES: The most essential point is the fact that we are ignorant of the compound action of the forces which are used. It is quite true that when one set of muscles is weakened, the corresponding set is strengthened and rotation takes place, after which deformity ensues; but just what forces are used, we do not know, and it is just this which seems to me the true scientific basis of the study of this condition. If this could be determined, we should get at the rational method of treatment. The body of a vertebra may be made stretched by action, just as, by action, we make the tissues surrounding it more elastic. To my knowledge there is no medical book published which treats of the compound action of muscular force. Moreover, this seems to me the logical treatment of the disease, and until we treat scoliosis by the above method, we are doing so empirically.

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**Nervous Dyspepsia.**

℞ Tinct. nucis vomica..... 3ij
Elix. calisayae val..... .. 3xxij
Elix aromatic... ... ..... 3xxij
M. Sig.—Teaspoonful before each meal.

# PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M. D.

## MEDICINE.

### Death-Rate of Large Towns.

The following table shows the mortality of the cities, of this country and Europe having a population of 100,000 or more:

| | Population | Deaths | Death-rate per 1000 |
|---|---|---|---|
| London | 5,849,104 | 55,895 | 17.11 |
| Paris | 2,424,705 | 28,675 | 23.61 |
| New York | 1,801,739 | 23,856 | 26.47 |
| Berlin | 1,669,124 | 17,181 | 20.58 |
| Chicago | 1,458,000 | 13,590 | 18.95 |
| Vienna | 1,435.931 | 18,005 | 25.07 |
| Philadelphia | 1,115.562 | 12,249 | 21.95 |
| Brooklyn | 978,394 | 10,682 | 21.84 |
| St. Louis | 520,000 | 4,802 | 18.47 |
| Brussels | 488,188 | 4,359 | 17.86 |
| Boston | 487,397 | 5,816 | 23.88 |
| Baltimore | 455,427 | 4,806 | 21.10 |
| Dublin | 349,594 | 4.735 | 27.05 |
| San Francisco | 330,000 | 3,006 | 18.21 |
| Cincinnati | 305,000 | 3,000 | 19.67 |
| Cleveland | 290,000 | 2,538 | 18.19 |
| Buffalo | 290,000 | 2,361 | 16.28 |
| Pittsburg | 255,000 | 2,923 | 22 92 |
| New Orleans | 254,000 | 3,298 | 26.72 |
| Edinburg | 267,000 | 2,572 | 19.22 |
| Milwaukee | 250,009 | 2,000 | 16 00 |
| Louisville | 227,000 | 1,630 | 14.80 |
| Minneapolis | 209,000 | 1,004 | 9 60 |
| St. Paul | 155,000 | 745 | 9.61 |
| Christiana, Norway | 156,500 | 1,385 | 17.75 |
| Denver, Colorado | 150,000 | 871 | 11.61 |
| Rochester, N. Y | 144.834 | 1.291 | 17.87 |
| Rheims, France | 105,408 | 1,503 | 28.62 |

### Puerperal Sepsis; Its Prophylaxis and Treatment.

Dr. Robert A. Murray, read a paper with this title. Antisepsis during labor, he said, was believed to be as necessary as in surgery. Three antiseptics could be managed easily—corrosive sublimate, carbolic acid and creolin. The prophylaxis should begin with a bath and a change of clothing. The vulva especially should be cleansed carefully. A new rubber cloth should be spread over a clean sheet, and over the rubber there should be a draw-sheet. The importance of an enema should not be forgotten. A vaginal injection of a 1-to-3,000 solution of corrosive sublimate or of a two-per-cent. solution of creolin should be given before labor, but usually not after it. Creolin was to be preferred to corrosive sublimate, because it was something of a lubricant, while corrosive sublimate was distinctly astringent, and so facilitated laceration. An antiseptic pad and napkin should be applied, and never removed except for examination, which should not be more frequent than was actually necessary. The physician's hand should be scrubbed thoroughly and immersed in a 2-to-2,000 solution of corrosive sublimate or a two-per-cent. solution of creolin. The antiseptic pad should be applied again after the birth of the child and before the expulsion of the placenta. Retained membranes and pieces of placenta should be removed at once by the aseptic hand, and then an intra-uterine douche should be given. Fluid extract of ergot, in half-drachm or drachm doses, was to be recommended in the majority of cases. After urination an antiseptic solution should be applied. When there was a bad odor to the discharge a vaginal douche was to be ordered, but if the examining finger showed that the foul discharge came from the uterus, it must be thoroughly curetted and a single uterine douche given. In prolonged cases instruments were to be employed. The nurse should never be allowed to examine a patient. In case of sepsis, the same general plan of antisepsis should be followed, but the vagina ought to be inspected so that the diphtheritic membrane might not be carried into the uterus.—*N. Y. Med. Jour.*

### The Therapeutic Effects of Hot Baths.

Topp (*Therap. Monatsh.*, January-February, 1894), with the view of testing the effects of hot baths, performed a number of experiments on himself, with the following results. In the first place, the articles in the daily diet were carefully weighed and compared with the elimination of nitrogenous compounds. On the first and second occasions the anthor remained for a quarter of an hour in a bath at temperature of 115° to 116° C. The body temperature at the same time rose to 105° C. In spite of the perspiration produced the amount of urine passed during the ensuing twenty-four hours was increased, and more particularly the absolute weight of nitrogenous material. The body temperature sank gradually to the normal. For practical purposes three to four baths daily, at a temperature of 105° to 109°, are recommended when the indiqidual can remain in the water about 40 to 45 minutes, and when the beneficial effects are even more marked. The author therefore agrees with Baelz in considering hot baths in the above form indicated in cases of capillary bronchitis and lobular pneumonia · also in rheumatism, nephritis, exudations, obstructive dysmenorrhœa, etc., but contra-indicated in cardiac affections.—*British Med. Iour.*

### Rheumatism, Acute.

℞ Sodii salicylat..... 3viss
Aquae ..... 3i
Syr. tolutan, q. s..... 3iij
M. Sig.—Teaspoonful every two hours.

### Chloroform in Lead Colic.

Dr. F. MacFarlan, of New York (*The American Therapist*, April), remarks that he has had great success in the treatment of lead colic by the internal administration of chloroform. He gives ten minims every half hour, if required. The pain is speedily relieved by the drug. The other features of the treatment go on in the usual way, such as the use of potassium, iodide and laxatives. The chloroform is decidedly more effective in easing the pain than morphia, as a trial of the two remedies will abundantly prove. The speedier relief also favours a quicker and more satisfactory recovery.

### Growing Pains.

Parents have for a long time handed down to succeeding generations the tradition that pains in the limbs of a growing child are a necessary evil and not associated with any one disease, and physicians have generally encouraged this theory: but Dr. P. B. Bennie, in the *Archives of Pediatrics*, has completely ignored this idea and argues that all pains in growing children are due to some specific cause, such as myalgia from fatigue, rheumatism, disease of the joints, fevers, adenitis, etc., in which rapid growth is only a concomitant and not a causal constituent. He says in conclusion: "This malady, 'growing pains,' with its frequent concomitant, growing fever, like its congener, disorders of dentition, vanishing from the realm of pathology through that of fancy, is fast sinking into oblivion in the medical literature of the past. As a separate morbid entity it exists now principally as an article of faith. The complaint still maintains, however, a strong hold of the lay mind and forms an extremely common lay diagnosis which is often the cause of much suffering and even death through leading to the neglect of curative measures at a time when they are most effective. But the day is approaching when its grip will be loosened, for the history of medical superstitions shows that they begin to wane first among the thinkers in the profession, and finally disappear among the uneducated laity and "growing pains" will be found to be no exception to the rule."—*Maryland Med. Jour.*

### Three Kinds of Head Pains.

Dr. Dana, New York (in *The Post-Graduate* for April), calls attention to the three following varieties of head pains : (1) Migraine, which is constitutional; (2) headaches of a diffuse kind and are due to overwork, eye-strain, etc., and (3) neuralgia. Migraine patients suffer most in damp weather and in the spring. Neuralgias of the head are of two forms (a) supra-orbital, infra-orbital and detail forms, (b) Tic douloureux. The first group of neuralgias is usually due to decayed teeth, or cold. The second form is rare, comes later in life, and oftener in men than women. It is extremely, obstinate, and may last for many years. Tic douloureux is frequently associated with obliterating arteritis. This gives rise to nerve anæmia and degeneration. Nitro-glycerine and aconite sometimes relieves, by acting upon the arteries, lessening their tension. Hypodermic injections of strychnine are often helpful.

## SURGERY.

### Guaiacol in the Treatment of Blennorrhagic Epididymitis.

At a recent meeting of the *Societe medicale des hopitaux*, of Paris, a report of which we find in the *Union Medicale* for April 10th, M. Balzer and M. Lacour stated that they had obtained excellent results in the treatment of blennorrhagic epididymitis with guaiacol. On the skin of the inguinal region, they said, pure guaiacol could be applied; on the scrotum it was better to employ an ointment of from two to five parts of guaiacol to thirty of vaseline. One of the first effects of the application of this ointment was a rather sharp burning, lasting for about ten minutes; then the patient felt a sensation of heat, and almost immediately the pain disappeared, at least for three or four hours, and sometimes it did not return. Ordinarily it was necessary to make two applications on the first day, but after the third day there was no longer any pain. The applications were then discontinued, for they did not seem to exert any very decided resolvent action upon the inflammatory infiltration of the epididymis. It was evident, the authors said, that guaiacol exerted a very clear and energetic effect upon the pain of the disease; moreover, it overcame certain of the general symptoms which were due to the pain, for example, sleeplessness. It gave rise to a slight erythema of the scrotum, followed by drying and exfoliation of the epidermis. The authors had treated twenty cases with guaiacol, and in all of them the results had been most favorable and very rapid.—*New York Medical Journal.*

### How Ought we to Treat Gonorrhœal Epididymitis.

Dr. Henri Picard (*La France Medicale*) answers this question by stating that there is, or has been, constipation for a few days. This requires a purgative to free the digestive canal, and will relieve the compression on the rectum, the prostate and the urethra. The drastics, and especially aloes, should not be ordered, but the salines or castor oil. If the constipation continues, use large enemata.

Rest, in the horizontal position, is the next point to attend to. Along with this a good support must be fitted to the testicle. This affords a great deal of relief; and permits the patient to turn in bed without pain, and, in sub-acute cases, to move around the room. Horand's support is the best. This support is made of a large piece of lozenge-shaped linen, split at the lateral angles, and lined with a thick layer of cotton wool, placed on vulcanized linen. By means of the angles this support can be fastened to the body, so as to hold the scrotum and testicles, and afford gentle pressure.

Demulcent drinks are of much value. They soothe the inflamed urethra, and render the urine less irritating. Linseed tea, infusion of violets, orange water, etc., are very good forms of drinks, and should be taken in large quantities.

A bath once or twice a day, or every other day, of the temperature of 95° F. is useful. These baths require to be prolonged. There is not much benefit from them unless kept up for some time. They calm the pain and favor sleep.

For the pain and tenderness the best remedy is salicylate of soda in doses of

three to four grms. daily. Antipyrine has been used with advantage; and the anemone pulsatilla has been found very beneficial in allaying pain and swelling.

When there is much swelling, redness of the skin, and the scrotum and testicles are very painful and tender, half a dozen leeches should be applied along the cord. If the condition of the tissues is serious, even a dozen may be used.

Later on, iodide of potash ought to be employed to remove the induration and enlargement that has been left by the disease. Mercurial strapping or ointment, may also be employed for these conditions. In spite of all efforts it is sometimes impossible to restore the testicle and epididymis to their normal size. The vas deferens is sometimes obliterated and the seminal fluid cannot make its way from the corresponding testicle.

## OBSTETRICS.

### Single Ligation of the Cord in Obstetric Practice.

According to the *Boston Med. and Surg. Jour.* of March 1, 1894, Nguyen Khac Can bases his opinion of the superiority of a single ligature upon his observation that out of sixty-eight cases of labor with double ligature of the cord, there were four cases of retention of the placenta, and out of one hundred and forty-six cases with single ligature, only two cases of retention. The duration of the third stage with the double ligature averaged sixty-four minutes, while with the single it was but twenty-seven minutes.

The author believes that a rapid diminution in the size of the placenta, due to the free escape of the intra-placental blood, favors retro-placental hemorrhage and consequent complete separation of the placenta, and that it further lessens the obstacle to its escape from the uterus and vagina by the resulting decrease in size. He recommends that double ligature of the cord should be reserved for cases of twin pregnancy. While we think that there is a question as to the correctness of the author's reasoning on the first point, there can be no doubt as to the advantage of diminishing the size of any body which is to pass the os uteri, and we have ourselves noticed a greater ease of delivery of the placenta in cases in which but one ligature had been applied.

The suggestion of Nguyen Khac Can is certainly of value. It should be easy to prevent untidiness by catching all the intraplacental blood in a suitable basin, but the determination not to check intraplacental hemorrhage, of course, implies a careful palpation of the uterus before the cord is cut, and an absolutely positive elimination of the possibility of a twin pregnancy.—*Therap. Gazette.*

### Chronic Headache.

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|---|---|
| Arseniate of sodium | gr. ss |
| Sulphate of atropine | gr. ss |
| Extract of aconite | gr. viiss |
| Powd. cinnamon, q. s. | |

Mix and make into 30 pills. Sig.—From one to four pills daily.

—*Dr. Zeutler in La Riforma Medica.*

## ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM JUNE 10, 1894, to JUNE 23, 1894.

Leave of absence for one month on surgeon's certificate of disability, with permission to apply to the proper authority for an extension of three months, is granted Major Joseph R. Gibson, surgeon, Fort Snelling.

PROMOTIONS.

First Lieutenants Philip G. Wales and Benjamin L. TenEyck, Assistant Surgeons, to be Assistant Surgeons with the rank of captain, June 7, 1894, after five years' service in conformity with the act of June 23, 1894.

First Lieutenant Deane C. Howard, Assistant Surgeon, is relieved from duty at Fort Buford, North Dakota, and will report in person to the commanding officer, Fort Snelling, Minn., for duty at that station.

The leave of absence on surgeon's certificate of disability granted Major Joseph R. Gibson, Surgeon, is extended three months on surgeon's certificate of disability.

Leave of absence for one month, on surgeon's certificate of disability, is granted First Lieutenant Frank T. Meriwether, Assistant Surgeon, with permission to leave the limits of the Department.

Major James C. Merrill, Surgeon, is relieved from duty in the office of the Surgeon-General, to take effect July 1, 1894, and ordered to report in person to the commanding officer, Fort Sherman, Idaho, for duty at that station.

Leave of absence for three months to take effect July 1, 1894, is granted Major James C. Merrill, Surgeon.

## NEWS AND MISCELLANY.

### New Hospital Managers.

The Governor of New Jersey recently appointed the following gentlemen as members of the new Board of Managers of the State hospitals: Mr. George Richards, Dover; Dr. Romeo F. Chabert, Hoboken; Rev. Dr. J. M. Buckley, Morristown; Mr. George B. Jenkinson, Newark; Mr. Patrick Farrelly, Morristown; Mr. Lewis Parker, Trenton; Mr. Charles E. Green, Trenton; Mr. John Howe, Monmouth. The new Board appears to be made up of the right material. The Rev. Dr. Buckley, editor of the *Christian Advocate*, of this city, is known to be a great friend of the insane, and for more than twenty-five years has manifested a warm interest in bettering their condition everywhere. With the advent of the new Board into power, partisan considerations will undoubtedly cease to pertain in the State hospitals of New Jersey. The present medical officers of these hospitals, who have so vigorously endeavored to keep the great charitable institutions under their charge beyond the grasp of political despoilers, ought to feel encouraged at seeing the dawn of what appears to be a new era.—*Medical Record.*

George G. Shoemaker, M. D., died at his home at Knox, Pa., on May 20th, 1894. Age 38 years.

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